Predoctoral Psychology
Internship Program

2012-2013

Veterans Health Administration
Medical Center
Dayton, Ohio

Inquiries and application materials should be addressed to:

Director of Training
Psychology Internship Program (17P)
VA Medical Center
4100 West Third Street
Dayton, Ohio 45428

Phone: (937) 268-6511, Ext. 1079
FAX: (937) 267-5385
Email: 552internship@va.gov

National Matching Service Program Code

151211	General Psychology Internship
151212	Pre Post Doc Neuropsychology

Accredited by the American Psychological Association
Commission on Accreditation
Office of Program Consultation and Accreditation
750 First Street, NE
Washington, DC 20002-4242
Phone: (202) 336-5979

Member of the Association of Psychology and Postdoctoral Internship Centers
10 “G” Street, NE Suite 440
Washington, DC 20002
Phone: (202) 589-0600

TABLE OF CONTENTS

OVERVIEW 5
INTERNSHIP TRAINING PROGRAM 5
Philosophy 5
Title 6
Model 6
Mission 6
Approach to Training 7
Goals 8
Objectives/Competencies 8
Completion 12
Evaluation 17
ROTATION FORMAT AND ASSIGNMENT 17
ROTATIONS AND CONCEPTUALIZATION STATEMENTS OF TRAINING SUPERVISORS 18
Health Psychology 18
Description 19
Conceptualization Statements 19
Mental Health 23
Description 23
Conceptualization Statement 22
Psychosocial Rehabilitation Programs 23
Description 23
Conceptualization Statement 23
Family Services Supplementary Experience 25
Description 27
Conceptualization Statement 26
Neuropsychology 30
Description 30
Conceptualization Statements 31
Posttraumatic Stress Disorder Program 33
Description 33
Conceptualization Statement 31
Substance Abuse Treatment Programs 39
Description 36
Conceptualization Statement 38
Geropsychology Rotation 41
Description 41
Conceptualization Statements 42
ADDITIONAL TRAINING EXPERIENCES AND SUPPORT 45
Training Seminars 45
Group Supervision 46
Testing Laboratory 46
Library 46
Medical Media 46

Professional Development 46
PHYSICAL SETTING AND SUPPORT 47
APPLICATION 47
Eligibility 47
Appointment and Benefits 49
Application Procedures 49
DIRECTIONS TO THE VHA MEDICAL CENTER 47
MATCH DAY 51
PSYCHOLOGY TRAINING COMMITTEE 52
INTERVIEW DATES AND ROTATION PREFERENCES 58

OVERVIEW

The Veterans Health Administration (VHA) is part of the Department of Veterans Affairs which is a cabinet level organization. The VHA Medical Center, Dayton, Ohio offers a full time, one year, funded predoctoral internship to doctoral students enrolled in clinical or counseling psychology programs that are accredited by the American Psychological Association (APA). Our psychology internship program is accredited by the APA. We were awarded seven year accreditation in April, 2010. Our next regularly scheduled site visit will be during 2016.

The origin of the Dayton VHA Medical Center dates back to March 3, 1865, when President Abraham Lincoln signed into law an act of congress establishing the National Home for Disabled Volunteer Soldiers to care for disabled Veterans of the Union Army. Dayton, Ohio was one of three original sites selected. Originally, the grounds consisted of 355 acres west of the city of Dayton. Lakes, surrounded by scenic trails, provided a pleasant atmosphere for relaxation and rehabilitation. A large farm provided much of the produce used by the Veterans. By the turn of the 19th to the 20th century, Dayton was the largest facility in the National Soldier's Home System. During 1930, when the Veterans Administration was formed, the National Soldier's Home System was discontinued and incorporated into the new organization. During 1989, the Veterans Administration was made a cabinet level organization and the title was changed to the Department of Veterans Affairs.

The medical center is located at the west edge of Dayton, Ohio. Much of the pastoral setting was preserved while establishing a modern, state of the art comprehensive medical facility. The current complex consists of approximately 60 buildings on about 240 acres. The medical center provides a broad spectrum of programs in primary, secondary, and most levels of tertiary care. The medical center serves 29 counties in central and western Ohio along with one county in Indiana with a total patient population of about 380,000. There are approximately 6500 inpatient stays and 350,000 outpatient visits each year. The medical center is a teaching facility that has numerous affiliation agreements with colleges, medical centers, medical schools, universities, and training programs throughout the area along with sharing agreements with other medical centers in the area and the Department of Defense. The medical center has excellent research facilities along with administrative and clinical support of such activities. The Dayton Department of Veterans Affairs Medical Center is a well established multicultural setting that employs about 1600 full-time employees who reflect considerable diversity.

INTERNSHIP TRAINING PROGRAM

Philosophy

We believe the internship year is crucial in the transition of the individual from student to professional. We encourage the development of professional knowledge, skills, and

beliefs/attitudes that form the basis for a solid professional identity along with the competent practice of psychology. We encourage individual professional responsibility while recognizing the importance of communicating and sharing responsibility with other professionals. Interns are encouraged to be innovative and creative with their professional development while using well established principles, techniques, and procedures as a basis for professional activities. In the perennial balance of medical center and training needs, we recognize that a high quality training program must be designed for the needs of the interns.

Title

We use the title of Psychology Intern.

Model

The Practitioner-Scholar Model is consistent with the mission of the VHA which includes: patient care, education/training, and research.

The Dayton VAMC Psychology Internship Program philosophy is consistent with the Practitioner-Scholar model (Vail model) of academic training and practice as summarized by Rodolfa et al. (2005). This model emphasizes the “mutuality of science and practice" and the practical application of scholarly knowledge. Psychological science is viewed as a human practice, and psychological practice is construed as a human science, with the two informing each other. The model emphasizes the development of reflective skills and multiple ways of knowing in the practice of psychology. It stresses clinical practice and the importance of theory and the use of research to inform practice. Students are trained to be psychologists who think critically and engage in disciplined inquiry focused on the individual and who gain clinical experience rather than conducting laboratory science. Consistent with the ACCTA definition of practitioner scholar programs, it is also our philosophy to "include empirically supported treatments, a value on the psychologist as a consumer of research, recognition of the importance of generating knowledge through practice, and an expectation that interns participate in scholarly activities". Our pedagogical approach to the application of this model is that of a developmental/apprenticeship process that "nurtures people in making the transition from trainee to competent autonomous professional, thus helping them to integrate their personal and professional selves; places a high value on respecting the diversity and uniqueness of every individual; and underscores the importance of supervisory relationship and the mentoring process".

Mission

We take pride in our profession and in the training of interns to become psychologists. We recognize the special responsibilities associated with the training of interns. The mission of the Psychology Internship Program is to

establish and maintain an environment that maximizes the potential for professional development for each psychology intern.

Approach to Training

There are various forms of supervision. Within the internship program, we define supervision as “Supervision for the Purpose of Training.” This is meant to reflect: The inherent complex social relationships that occur with supervision for the purpose of training that are operated on a number of levels simultaneously. We recognize, and are sensitive to, the multiple levels.

Four components of supervision for the purpose of training
Formal knowledge
Skills/experience
Attitudes/beliefs
Safety of patients

The developmental quality of supervision for the purpose of training.

We utilize a programmatic approach to training. Within a programmatic approach, each intern enters an ongoing patient care system and performs the duties of a psychologist. Within the context of this programmatic approach, the apprenticeship approach is utilized to varying degrees. Variation is due to the specific needs of each intern and the tasks being learned.

We have adopted situational leadership theory as our conceptual basis. The role of a training supervisor evolves as an intern develops competence in a given task: direct, coach, consult, independence. The theory is elegant in its simplicity and incorporates well the developmental nature of a psychology Internship.

Within the various guidelines, rules, regulations, laws, standards of care, and models that govern our professional behavior, training is individualized in order to meet the professional needs of each intern. We conduct ongoing and proactive discussion about training needs, wants, and expectations that begins before, and continues throughout, the internship year.

Our general approach is to behave in a manner consistent with American Psychological Association guidelines and Department of Veterans Affairs Policies regarding the disclosure of personal information and to routinely maintain good boundaries in that regard. Legitimate training supervision activities include, but are not limited to, the exploration of professional and personal values, the exploration of personal experiences along with their impact on the practice of psychology, the development of understandings regarding emotional reactions to events that occur during the course of professional activities, and the exploration of consistencies/inconsistencies between one’s personal behavior patterns and

behavior patterns that are consistent/inconsistent with good health and quality of life.

The Psychology Internship Program was developed to assure high quality training. We have developed a specific, competency based approach. The competencies notion is applied to all aspects of the training program. Within the context of this competency based structure, both positive and negative feedback have heuristic value. Each serves to inform how well an element or process is functioning.

The Lead Psychologist and the Co-Directors of Training are administratively responsible for the Psychology Internship Program while the Psychology Training Committee (PTC) is the governing body. Regular meetings are held and the minutes are distributed to all staff and interns. Interns are members of the training committee. Training supervisors who are actively providing intern supervision are required to attend all PTC meetings. While training supervisors who are not actively supervising interns are not necessarily required to be at all meetings, attendance is recommended and encouraged. Although the members of the training committee work toward consensus when making decisions, a simple majority vote is all that is required.

Goals

We designed the internship program to provide a broad predoctoral training experience that forms a sound basis for a professional career. The focus is on the acquisition and/or development of formal knowledge, professional skills, and attitudes/beliefs that make for a solid professional identity. The expectation is that, by the end of the training year, an intern will be able to function competently (i.e., entry level or better) across multiple foundational and functional areas including: Ethical/Professional Issues, Assessment, Intervention, Diversity/Multicultural, and Science and Practice. We emphasize general skills with an adult population. Within the context of sound professional growth, however, we support actively the development of specialist skills.

Objectives/Competencies

Our overall goal is for each intern to be fully prepared for entry level practice. Entry level practice is defined as being fully prepared to begin the required period of supervision prior to licensure. It is the equivalent to a GS-11 psychologist in the Department of Veterans Affairs.

The foundational and functional competencies defined by the APA's Assessment of Competency Benchmarks Work Group (2007), including Ethical-legal standards-policy and Individual-cultural diversity, are evaluated across rotations. Each rotation has some unique competencies that may vary in the areas of Assessment, Intervention, and Consultation. All rotations have specialized

competency requirements for Science and Practice. The competencies are documented on formal competency evaluation forms. What follows are broad statements regarding the areas evaluated and examples of some of the behavioral anchors assessed.

Foundational Competencies:

Reflective Practice Self-Assessment

Practice conducted within the boundaries of competencies, commitment to lifelong learning, engagement with scholarship, critical thinking, and a commitment to the development of the profession.

Demonstrates awareness of individual strengths and areas in need of improvement
Changes behavior based on self-monitoring
Keeping up with advances in profession
Demonstrates awareness of the impact behavior has on public and profession

Scientific Knowledge- Methods

The ability to understand research, research methodology and a respect for scientifically derived knowledge, techniques of data collection and analysis, biological bases of behavior, cognitive-affective bases of behavior, and lifespan human development.

Ability to independently access and apply scientific knowledge & skills appropriately and habitually to the solution of problems
Demonstrates knowledge of and respect for scientific knowledge of the bases for behavior, and incorporates this into professional practice
Student reviews scholarly literature related to clinical work and applies knowledge to case conceptualization

Relationships

Capacity to relate effectively and meaningfully with individuals, groups, and/or communities.

Maintains satisfactory interpersonal relationships with clients, peers, faculty, allied professionals, and the public
Demonstrates understanding of diverse viewpoints
Adheres to ethical standards and institutional policies and procedures
Descriptive, understandable command of language, both written and verbal

Ethical-Legal Standards-Policy

Application of ethical concepts and awareness of legal issues regarding professional activities with individuals, groups, and organizations. Advocating for the profession.

Observance of the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct, and Department of Veterans Affairs rules, regulations, and laws as well as other documents that govern our professional behavior
Aware of potential conflicts in complex ethical and legal issues and seeks to prevent problems and unprofessional conduct
Develops strategies to seek consultation regarding complex ethical and legal dilemmas
Takes responsibility for continuing professional development of knowledge, skills, and attitudes in relation to ethical-legal-standards and policies

Individual-Cultural Diversity

Awareness and sensitivity in working professionally with diverse individuals, groups and communities who represent various cultural and personal background and characteristics.

Able to critically evaluate feedback and initiate consultation or supervision when uncertain about diversity issues
Habitually adapts one's professional behavior in a culturally sensitive manner, as appropriate to the needs of the client, that improves client outcomes and avoids harm
Seeks consultation regarding addressing individual and cultural diversity when relevant

Interdisciplinary Systems

Identification and involvement with one's colleagues and peers. Knowledge of key issues and concepts in related disciplines and the ability to interact with professionals in them.

Demonstrates ability to work successfully on interdisciplinary team
Demonstrates skill in interdisciplinary clinical settings in working with other professionals to incorporate psychological information into overall team planning and implementation
Evidence of systematically collaborating with other relevant partners
Appreciates and integrates perspectives from multiple professions

Functional Competencies:

Assessment-Diagnosis-Case Conceptualization

Assessment and diagnosis of problems and issues associated with individuals, groups, and/or organizations.

Treatment plans incorporate relevant developmental features and clinical symptoms as applied to presenting problem
Administers, scores and interprets test results
Awareness of and ability to use culturally sensitive instruments, norms
Selection of assessment tools reflects a flexible approach to answering the diagnostic questions
Comprehensive reports include discussion of strengths and limitations of assessment measures as appropriate
Ability to write a comprehensive report
Ability to provide meaningful, understandable and useful feedback that is responsive to client need

Intervention

Interventions designed to alleviate suffering and to promote health and well-being of individuals, groups, and/or organizations

Presents rationale for intervention strategy that includes empirical support
Accurately assesses presenting problem taking in to account the larger context of the client's life, including diversity issues
Ability to independently and effectively implement a typical range of intervention strategies appropriate to practice setting
Ability to terminate treatment successfully
Ability to critically evaluate own performance in the treatment role
Uses good judgment about unexpected issues, such as crises, use of supervision, confrontation

Consultation

The ability to provide expert guidance or professional assistance in response to a client's needs or goals.

Demonstrates ability to gather information necessary to answer referral question
Ability to recognize situations in which consultation is appropriate

Research/evaluation

The generation of research that contributes to the professional knowledge base and/or evaluates the effectiveness of various professional activities

Engages in systematic efforts to increase the knowledge base of psychology through implementing research
This competency requirement may be met with the successful completion of dissertation work (independent research on this internship is not required or expected)

Supervision-Teaching

Supervision and training of the professional knowledge base and/or evaluates the effectiveness of various professional

Able to articulate a philosophy or model of supervision and reflect on how this model is applied in practice
Awareness of potential conflicts in complex ethical and legal issues that arise in supervision

Management – administration

Managing the direct delivery of services and/or the administration of organizations, programs, or agencies.

Responds promptly to organizational demands
Participates in the development of policies

Science and Practice

Demonstrates knowledge and skills necessary for the specific rotation performance being evaluated.

Able to identify risk factors for suicide
Awareness of individual and cultural differences in accessing and utilization of mental health services
Completion of required reading including current literature pertinent to the rotation

Completion

Completion of the internship program is conditional upon an intern meeting the stated objectives along with professional behavior that meets or exceeds competencies. No partial credit is granted regarding the internship. Successful completion of the internship is an all-or-none decision.

Interns are rated from Level 0 – Level 5 across each competency area and then given an overall score for each rotation. Level 3 reflects "many skills in this area have been acquired and intern works with moderate supervision." Level 4 reflects "most skills in this area have been acquired and intern works with minimal supervision."

For successful completion of the internship, an intern must have on all rotations, a Final Rotation score at or above Level 3.

Two of the four rotations must have an overall competency score of "Level 4" or greater. If an intern takes a 6-month special emphasis rotation, an overall score of "Level 4" or greater must be obtained for that rotation.

In addition, minimum levels of competency are required in essential domains such as assessment, intervention, and multi-cultural competence.

At the beginning of each rotation, the assigned supervisor(s) will review the competency assessment with the intern and clarify critical domains for that professional experience. Overall rotation scores should flow naturally from the scores assigned, however, specific domains may have greater or lesser weight from one rotation to another (i.e., neuropsychology – assessment skills; MHC – intervention skills).

Despite some variability, there are Critical Foundational skills our program considers essential for the development of all psychologists. As such, the following minimum competency thresholds must be obtained in order to be granted an overall score greater than or equal to Level 3:

Critical Foundational Competency Components	**Minimum Score for Rotations 1 and 2**	**Minimum Score for Rotation 3**
Reflective Self-Assessment B. Self-Assessment and Self-Care	3	4
Scientific Knowledge B. Knowledge	3	4
Relationships B. Affective Skills	3	4
Individual-Cultural Diversity A. Self-Awareness	3	4
Ethical-Legal Standards-Policy C. Ethical Conduct	3	4

In addition to the above mentioned Critical Foundational Competency requirements, the intern must obtain a minimum **average score of 3** in each rotation-specific Science and Practice domain.

Throughout the internship year, the intern will receive ongoing evaluation. If, at any point, the supervisor evaluates the intern to be performing at a substandard level, or if the intern scores lower than the minimum required scores in the Critical Foundational Competency or rotation-specific Science and Practice areas, this will prompt a remediation plan to go into effect. This written remediation plan will be developed by the intern's primary supervisor with the intern's input. The plan will be tailored to meet the specific needs of the intern in order to enhance the areas of substandard performance and to support the intern in meeting the minimum required standards.

If the intern does not respond to remediation (i.e. continues to perform at substandard level), due process procedures will be implemented.

Program Requirements for Successful Completion of the Internship

Diversity special emphasis including completion of:

Diversity Project: Place yourself in an environment where you are the minority. Situations might include a religious ceremony that is different from your own, a particular social event that you are not used to being a part of. Think about diversity in terms of: ethnicity, SES, religion, sexual orientation, education, disability, age. Write a reaction paper based on this experience. This is to be completed by the end of January and will be discussed in the diversity seminar.
Family Origin Rules & Expectations: Investigate the cultural influences of your development. How does your family's ethnic, religious, SES, sexual orientation, etc., help form your sense about what is acceptable and not acceptable. Discuss this topic with at least one parent or grandparent to seek clues to particular cultural influences. Submit a summary about what you have learned. To be completed by the end of June and process with your MHC supervisor.
Diversity Seminar: Every other month we will process diversity issues in a group format—This will be scheduled as part of two diversity related journal presentations, one intern discussion of the diversity project, and three diversity related case presentations (each intern will present one diversity case, and participate in discussion of the others) during the group supervision meetings.

Case conceptualization and presentation

Present two case studies in a didactic presentation, which employs your theoretical orientation including evidence based treatment. Explain your conceptualization of patient's symptoms and diagnosis based on your orientation. You are to include audio or video-taped parts of sessions. This will occur over the course of six, 9:00am group supervision meetings. (2 articles describing the theory and evidence based treatment)

Caseload sufficient that a minimum of 10 client hours/week face-to-face direct service is provided.
During the year services must be provided to a minimum of 5 Veterans with serious mental illness.
Within the first month of internship, students are encouraged to contact their respective licensing board to ascertain if this requirement will fulfill their state licensing requirement.

12 comprehensive assessments that respond to the referral question and integrate appropriate data to provide diagnostic and/or treatment recommendations.
This would include neuropsych, transplant, mental health, PTSD, substance abuse. Specific requirements are listed below.

Lead or Co-lead at least 2 psychotherapy (either psycho-educational or process-oriented) groups with a minimum of 6 sessions each

Video or audio-tape sessions or be involved in “live” supervision.
A sampling of assessment and/or therapy sessions at the beginning of the rotation will be observed by the rotation supervisor either via means of audio/video recording or through live observation. Recording or live observation throughout the duration of the rotation will be left up to the discretion of the rotation supervisor who will base their decision on intern needs, interest, and time availability/practical logistics.
have tape ready for supervision
provide information for case conceptualization (see #2)

Attend all intern didactics, including one on consultation and supervision unless on Leave Status

Complete Training Log and Patient Log

Attend 1 Grand-Round, either medical or psychiatric, per month, which is to be logged in the intern log booklet located in the MHC

Be prepared for and attend 4 hours of supervision per week
Intern supervision is regularly scheduled and sufficient relative to the intern’s professional responsibility assuring at a minimum that a full-time intern will receive 4 hours of supervision per week, at least 2 hours of which will include individual supervision.

Participate in Umbrella Supervision of Practicum Students, based on student availability and supervisor involvement in practicum training.

Write a brief paper (2-5 pages) identifying your conceptualization of the Process of Change in Psychotherapy. This will be turned in by the end of June to your MHC supervisor, processed, and then shared in group supervision with your intern class.

Comprehensive Assessment Requirement for Interns

A. A comprehensive assessment is an assessment that includes: 1) multiple data sources (e.g., thorough chart review, interview with staff/treatment team members, interview with pt's family/friends/etc, interview with pt, mental status, behavioral observations); 2) at least one standardized test/screening instrument/inventory or a specialty interview which tests the patient's psychological or cognitive status in some way (e.g., decisional capacity) and does not merely collect background information/history/symptoms/presenting problem as in a traditional clinical interview; and 3) integrates all this data into one coherent psychological report, which includes sections such as the following (as a general guideline): reason for referral, relevant background information, mental status, interview with patient, interview with collateral sources, test results/interpretation, diagnostic impression, recommendations/plan. (The specific style of the report may vary depending on service area and supervisor.)

B. Each intern will be required to complete 12 comprehensive assessments over the course of the internship year. Half of these assessments (i.e., 6) must each include a minimum of 3 standardized instruments/surveys/screens, at least one of which must be an objective personality measure (e.g., MMPI, PAI, MCMI). It is anticipated that all or most of these six assessments will be obtained in the MHC while performing intake evaluations. It is permissible, however, for some or all of these six assessments to be completed on other rotations if the opportunity arises, and the above requirements can be met.

C. The other six comprehensive assessments, will be rotation-specific, and need only to meet the general requirements as outlined in Section A. The goal of these assessments is to give the intern "real world" training with regard to how a psychologist working with a specific population in a specific setting will competently assess patients (e.g., substance abuse; PTSD; medically ill inpatients; cognitively impaired, seriously mentally ill, or elderly patients who cannot tolerate lengthy testing). An intern will be required to complete at least one of these assessments for every two months on a rotation (i.e., a 2-month rotation = 1 assessment; a 4-month rotation = 2 assessments; a 6-month rotation = 3 assessments).

D. Of the 12 comprehensive assessments that will be completed, the following is required:

- all assessments will include a section (narrative, not template) devoted to the patient's mental status and behavioral observations
- a minimum of 6 objective personality measures (i.e., MMPI, PAI, MCMI)
- a minimum of 3 cognitive screens (e.g., Cognistat, RBANS, MOCA, SLUMS, DRS) or neuropsychological instruments
- a minimum of 3 symptom inventories (e.g., BDI, BAI, STAI, GDS, PCLC, DAES, PHQ9)

(***All neuropsychological testing - this does not include cognitive screens - must be supervised by a staff psychologist with specialty privileges in neuropsychology***)

E. The intern is responsible: to keep a record of the number and type of assessments completed (on a log sheet that will be provided to them), to have their supervisor initial off on the log, to ensure that they are making steady progress throughout the year, and that they have fulfilled the requirement by the end of the year. The Co-Dots will ensure that the interns' progress towards completion of this requirement will be placed on the agenda and reviewed at PTC meetings every two months. A supplemental form will be attached to all mid- and end-rotation evaluations which will address whether the intern is meeting the comprehensive assessment requirement. (Both the intern and rotation supervisor will sign off on this form.)

Evaluation

Evaluations are an integral component of the internship training process and occur throughout the internship year. At the beginning of each rotation there is a general assessment of an intern's professional skills. There is a formal assessment of competencies about half way through a rotation and a formal assessment at the end of each rotation with feedback provided. At the end of each rotation, the intern also completes an evaluation form on the supervisor and rotation. At the end of the internship year each intern completes formal evaluations of the program.

ROTATION FORMAT AND ASSIGNMENT

Consistent with the guidelines and principles of accreditation, there will be contact between the training committee and an intern's graduate program prior to the onset of the internship year. Also, there will be interactions between the internship program and the intern. The goal is to have a tentative rotation structure in place prior to the beginning of the internship year.

There are two rotation length choices from which an intern can choose. Specifically, the intern can choose a 4-4-4 rotation length, in which the intern

would have three 4-month rotations. Alternatively, an intern can choose a 6-2-4 or 6-4-2 rotation length, in which he/she would have 6 months in one rotation, 4 months at another, and 2 months at a third. This option is often preferred by interns who desire to implement a professional developmental plan that includes particular clinical emphases or specializations. Please note that, while this internship program anticipates being able to meet such requests, any particular intern's rotation structure is decided upon on a case-by-case basis.

Each rotation is three days per week, regardless of whether the intern is completing a 2, 4, or 6-month rotation. Throughout the entire 12-month internship, a fourth day is spent performing general clinical work at the Mental Health Clinic (MHC), and a fifth day is utilized for training purposes (i.e., didactics, Grand Rounds, dissertation, etc.). Please note that, if an intern chooses, he/she may choose the MHC as one of his/her 2, 4, or 6-month rotations. In this case, the intern would then be at the MHC for a total of four days (i.e., three days for the MHC rotation plus the one required day all year) during the length of the MHC rotation.

We do recognize that, after arrival and familiarization with the setting, an intern may wish to change a rotation and/or the sequence of rotations. Also, we recognize that professional development plans can, and do, change. Our preference is for such changes to take place early on during the internship year (e.g., within the 1st month) in order to best accommodate both the intern and supervisors.

ROTATIONS AND CONCEPTUALIZATION STATEMENTS OF TRAINING SUPERVISORS

Please be advised that the rotation offerings in this brochure may change based on supervisor availability or other factors. Please check the website periodically for updates.

Training supervisors are psychologists whose responsibilities include the provision of supervision for the purpose of training. The statements are intended to be similar to the conceptualization statements written by applicants with an orientation toward the setting in which the supervisor engages in the practice and training of professional psychology.

Health Psychology

Description

The rotation in health psychology emphasizes the provision of psychological services in the medical primary care clinics at the medical center. Such services include: assessment of patients referred for a variety of issues – most commonly depression, anxiety, substance abuse, nonadherence to indicated treatment regimens, adjustment to medical conditions/disabilities, psychological factors impacting presentation of medical symptoms, and stress management. Interventions offered to primary care patients typically include brief, time limited treatments as well as psychoeducational activities such as health education groups. Each intern will become involved with the primary care team that consists of physicians, nurses, a psychologist, a psychiatrist, physician assistants, dieticians, a social worker, a pharmacist, and administrative associates.

Psychologists assigned to health psychology provide a range of other services. Such services include programs for chronic pain management, weight management, smoking cessation, and patient adherence issues. Consultation services are provided to specialty clinics and inpatient wards: cardiology, infectious disease, neurology, oncology, surgery, and rehabilitation. An additional important role in health psychology is responsibility for conducting evaluations of patients who are candidates for an organ transplant, bariatric surgery, and spinal cord stimulators.

While many of the training activities and professional responsibilities are established as part of the routine program, the rotation is designed with an orientation toward flexibility to meet an intern's specific professional interests and needs. One of the explicit competencies in all rotations is the provision of consistent messages to patients. An intern can anticipate an exploration of his/her personal behavior patterns (e.g., use of nicotine products) relative to behavior patterns that maximize good health and quality of life.

Conceptualization Statements

Stephen F. Hamilton, Ph.D.

How do I conceptualize my work as a psychologist? It has evolved over the years and been informed by many factors… books and articles I have read, people I have met, and experiences I have had. It has also been shaped by my 20 years in the Air Force, actively engaged in transformation both from a systems perspective down to the individual level. My approach is that of an activist, being actively engaged in the treatment of clients who are unique, diverse and have their own perspective on dealing with life's challenges.

I believe in the power and adaptability of the individual and seek to harness that power and adaptability into their treatment. Bottom line … I do what works, using the best research and evidence based treatments sprinkled with a little creativity to help move the individual forward.

I love a good story because I believe it is how we learn best. So what is my approach? I think it can be summed up by the following:

A young man was wrestling with a difficult challenge and told his friend "I have hit a wall, I can't see any way out." The young man and friend discussed his situation and then departed for the weekend. On Monday, the young man called the friend and told him "I had this realization after talking to you. I realized it was not a wall after all, but a pillar. I had gotten so stuck it only looked like a wall. But when I stepped back, got a new perspective, I realized it was a pillar that I could walk around and not into. "

Working in primary care and with chronic pain patients, it is a distinct honor and privilege to help individuals gain a new perspective and at times new hope by seeing their challenges as "pillars that can be walked around" vs. "walls that are run into".

Joshua W. Shuman, Psy.D.

The ways in which I conceptualize and treat therapy clients has changed and grown throughout my career. I started my first practicum as a pure Cognitive Therapy (CT) follower. Then, during my 4th year in graduate school, I was taught by Dr. Jeffrey Binder about Time-Limited Dynamic Therapy (TLDP). TLDP is a form of interpersonal/dynamic theory in which clinicians attempt to help clients uncover how their long-standing cyclical maladaptive patterns of relating to others, learned in childhood and behaviorally and socially reinforced throughout the years, have gotten them mired in repeating the same types of behaviors and relationships as adolescents and adults. An underlying assumption is that a client will play out those same functional and dysfunctional patterns of relating with the therapist. Nonetheless, interpersonal/dynamic theory is flexible enough to incorporate and utilize CT, CBT, traditional Psychoanalytic, and Humanistic concepts and interventions, while still keeping the focus on here-and-now therapist-client interactions so that clients can have "a [interpersonal] new experience" by relating to the therapist in ways that are qualitatively different from previous interpersonal interactions. As an interpersonal/dynamic therapist, my plan and goal is to use whatever therapy tools are in my toolbox (e.g., Motivational Interviewing [MI]; ABC/thought charts; DBT principles/interventions; unconditional positive regard; etc.) to help clients to believe and experience that they can reach their therapy goals. I learned those clinical tools from my practica, internship, and postdoctoral training and clinical experiences, as well as my post-licensure (March 2008) work, which has included: Visiting Assistant

Professor at Wright State University's School of Professional Psychology (SOPP); DBT treatment with adolescents and adults; inpatient; community mental health center; therapy with HIV/AIDS-affected individuals; GLBT clients; college counseling center; psychological assessment experience; and clinical supervision of multiple practicum students and interns.

A further major clinical interest of mine is psychological assessment. I specialize in personality assessments, especially with integrating projective (e.g., Rorschach; TAT) and objective (e.g., MMPI-2; MCMI-III) personality measures as a means of diagnosing and treatment planning. Further, I have much experience with psychoeducational testing (e.g., ADHD; MR; LD) and violence risk assessments. In addition, it seems to me that many clinicians undervalue how the integration of good working knowledge of the DSM, strong MI skills, and real client-centered empathy can aide in attaining accurate and pertinent information during a clinical/diagnostic interview. Thus, I believe that should be a core skill that is taught and practiced.

Lastly, I find providing clinical supervision to be a highly rewarding aspect of being a professional psychologist. I have, without a doubt, been molded and influenced by fantastic training supervisors. They taught me to believe in myself, even when I get a bad case of "imposter syndrome" sitting in the therapist's chair. They gave constructive criticism when I needed a gentle nudge to try something different with a client. They taught me innumerable clinical techniques, including how to just "be" with a client during their sadness, silence, or anger. But most importantly, they always encouraged me to be, simply, myself in the clinical room. Given how much I have learned from and valued the supervision I received, I have attempted to incorporate what I have learned and experienced with the practicum students I have supervised.

Ramon Verdaguer, Ph.D., ABPP (Clinical Health Psychology)

As Health Behavior Coordinator one of my responsibilities is to help develop processes that support adoption of healthy behaviors through education of, and consultation with healthcare delivery teams, and through direct patient contact.

We understand that treatment of chronic illness, such as coronary artery disease, diabetes, and hypertension is a major burden on VA Healthcare and on the Nation as a whole. We also know that often these illnesses could be prevented or ameliorated through adoption of healthy behaviors. As a result VA is re-emphasizing the importance of illness and disease prevention, in particular through primary care programs and primary care based interventions. The development of our Primary Care Patient Aligned Care Teams (PACT) is a major shift in the delivery of healthcare which emphasizes patient centeredness and illness prevention. For example, counseling about the health risks of smoking, and alcohol use as well as the benefits of exercise and a healthy diet, is now commonly integrated into routine primary care visits.

One of the roles of a psychologist in the primary care setting is to facilitate change in people who have identified the implementation of healthy behaviors as an effective mean to prevent and/or manage chronic illness and are prepared to embark in such a change. The Transtheoretical Model (Prochaska & DiClemente), a process theory of change, is a useful construct in determining who may be ready to embark in that change and to which interventions they may be more receptive.

Although skill acquisition and enlargement is an objective, the underlying goal is to assist in the development of a self-regulatory mechanism that can maintain and drive those positive behaviors on a long-term basis in the face of occasional lapses, frustrations, and lack of concrete positive feedback and reinforcement. The concept of *integration*, as defined by Deci et al. (1994) in the Self-Determination Theory perspective, in which a behavior is “volitional” and “emanates from oneself” and results in self-determined behavior seems to capture the essence of this aim. A combination of psycho-educational strategies, client-centered and cognitive-behavioral therapeutic interventions are useful in enabling individuals to attain this level of integration.

Yet, we also know that availability of information and education about the consequences of high-risk behaviors and the availability of alternative health behaviors does not always translate into positive behavior change. In that light, another role of the psychologist is to promote behavior change with those people who may not be necessarily ready or prepared to undertake such a change. In this case, it is important to acknowledge that people may not be ready to change for a variety of reasons. Some of these reasons may be the result of intrapersonal issues such as perceived susceptibility, low self-efficacy, ability, and outcome expectations. Environmental issues can also impact the decision to change and may include situational barriers or lack or resources, and demographic or sociological variables. Clearly, the nature and severity of the illness can also impact on a decision to change. The biopsychosocial model is, therefore, a useful umbrella framework through which to conceptualize the individual and the factors influencing readiness to change. It lays out an outline for inquiry that can lead to an actionable roadmap for intervention.

In general, the orienting principle of my work is to assist people to act in ways that are consistent with their life values and goals. As such, I conceptualize my work as involving 2 phases. The first phase moves forward the process of value elucidation, goal determination, and choice clarification. Cognitive, emotive, and experiential strategies tend to be most effective in this phase. This process leads to the second phase, which involves facilitating decision making and actions that are consistent with attainment of the goals. Behavioral strategies tend to have a good response during this phase.

This process implicitly accepts that some people's values and goals are not necessarily congruent with the clinician's values and that not everyone can, will, or should change. This may at times be incongruent with the institutional goals but its acceptance is crucial if one is to respect the individual and if one is to remain vitally committed to good patient care without losing oneself in the process.

Mental Health

Description

The program is structured such that, regardless of rotation setting, each intern spends one day per week in the Mental Health Clinic (MHC) for the entire internship year. This arrangement is intended to provide interns with the opportunity to follow therapy patients on a more long term basis.

A four month rotation would offer a variety of traditional psychotherapy as well as evidence based individual and group treatment. Participation is possible in a variety of outpatient groups.

The Mental Health Clinic rotation will afford additional opportunities to build competence in personality assessment and treatment planning. Supervision will be provided in the use of personality assessment measures.

We believe that core competencies in assessment and treatment of a general mental health population may be obtained through the one-day/week experience. It is our goal to offer experiences to those choosing a four month mental health rotation that will facilitate more advanced competencies and skills mastery, particularly in assessment and evidence based practice.

Conceptualization Statements

Belinda Chaffins, Psy.D.

My experience includes working in community mental health clinics, a state hospital, college counseling centers, private practice and at the VA. I have a great deal of assessment experience including instruments that measure cognitive processes, personality, achievement and memory. I was trained as a generalist at Wright State University and have developed expertise in the area of Sexual Dysfunctions/Sexual Health working with both individuals and couples. Other interests include women's issues, cultural issues, health and Alzheimer's disease and Caregivers. My orientation is based on Cognitive Behavioral as well as Humanistic principles. I have been trained in Integrative Couple Therapy developed by Neil Jacobson and Andrew Christensen.

Massimo DeMarchis, Psy.D.

Dear prospective intern, the Outpatient Mental Health Clinic offers the opportunity to work with a truly varied set of Veterans' needs, ranging from the sequelae of chronic severe mental illnesses to adjustment disorders, relationship problems, anxiety and depressive disorders. Substance use disorders, grief issues and adjustment to disability issues are other common issues. The MHC setting is known for the close and professional cooperation of various disciplines (nursing, psychiatry, social work and psychology). This setting will also offer the opportunity to conduct assessments for the inpatient psychiatry unit on a referral basis as well as the opportunity to conduct intakes/assessments on an outpatient basis. You will have the opportunity to lead or co-lead weekly psychotherapy groups (Anxiety and Depression and Anger Management).

My background is varied, as I have 13 years of experience working in a State Hospital with mostly chronic patients, typically court ordered, extensive experience performing Forensic evaluations, working with substance abuse, with sleep disorders and with general mental health issues, both in a private practice setting and in a State agency setting.

My orientation has typically been based on Cognitive Behavioral principles, and more recently has encompassed Acceptance and Commitment Therapy principles.

David Drake, Ph.D.

My work history includes experience in crisis triage, outpatient mental health assessment and psychotherapy, nursing home consultation, bariatric pre-surgical psychological assessments, and conducting disability evaluations for the Ohio Bureau of Worker's Compensation. I have worked in settings ranging from an outpatient division of a large metropolitan hospital, a university counseling center, and for over 11 years I have maintained a private practice. My training includes experience in both CBT and psychoanalytically-oriented psychotherapy. While I consider myself primarily psychodynamic in my clinical orientation and approach to case conceptualization, this theoretical orientation informs rather than dictates the specific interventions that I utilize in the course of any particular individual's treatment. One of the things that I love about the practice of psychology is the never-ending opportunity to grow both personally and professionally in the service of pursuing a calling to help others, and that includes a mindset of openness to the views of diverse treatment models (e.g., CBT; ACT Therapy; Interpersonal Psychotherapy).

Psychosocial Rehabilitation

Description

Psychosocial Rehabilitation (PSR) at the Dayton VA has rapidly expanded within the past three years and provides a continuum of care for Veterans with serious mental illness.

The Psychosocial Rehabilitation and Recovery Center (PRRC), also known as the “Building Bridges” Program, is an outpatient recovery center that provides daily-recovery focused services to Veterans who are diagnosed with serious mental illness and experience severe functional impairments in one of more areas.

The mission of the “Building Bridges” Program is to provide Veterans with services that will help them to take back their lives and take part in their communities. “Building Bridges” staff members fulfill this mission by providing Veterans with hope, focusing on their strengths, and teaching life skills that will help them reach their self-chosen goals.

Interns on this rotation will have the opportunity to learn how to deliver recovery-oriented services to a population with serious mental illness. Interns will learn the basics of psychiatric rehabilitation that focus on helping Veterans achieve self-identified goals for recovery, better psychosocial functioning, and greater integration into the communities of their choosing. Interns will have opportunities to conduct biopsychosocial assessments that focus on helping Veterans identify recovery goals; to provide individual recovery coaching sessions to help Veterans problem-solve towards goal achievement; and to facilitate psychoeducational and skills-based groups, such as Social Skills Training, Illness Management & Recovery, and Wellness Recovery Action Planning.

Interns involved in the Psychosocial Rehabilitation rotation may also choose to participate in the Family Services supplementary experience (see below).

Conceptualization Statements

Justin Bunn, Psy.D.

I am a firm believer that if an individual is given the opportunity, resources, and support, they can work toward and achieve their self-chosen goals. I believe this begins with the therapeutic relationship, which research has thoroughly shown to be one of the primary avenues for change in any client who presents for treatment. Within the therapeutic alliance, I tend to be guided by a cognitive-behavioral, interpersonal, and client-centered perspective with a focus on

collaboratively developing an understanding of presenting problems within the context of understanding the individual from a biopsychosocial framework.

My training has taken an interesting path through a variety of settings, populations, and experiences. I've worked with at risk children and adolescents at a state-funded residential school, a Christian-based private practice, a neuropsychological program within a larger private hospital, and programs across the VA both as a practicum student at the Dayton VA, and a pre-doctoral intern at the North Chicago VA. All of these experiences have been vital in my development both professionally and personally. In particular, my training as a pre-doctoral intern significantly shaped my professional identity and continues to guide me through the art and science of psychological practice. Working with both outpatient and residential PTSD, neuropsychology, and the Domiciliary/Homeless program I began to understand that while I may have certain theories and psychological perspectives, every individual is different, which requires a certain amount of flexibility in my conceptualization. My training has focused specifically on cognitive-behavioral (CBT), cognitive-processing (CPT), interpersonal (IPT), dialectical behavior therapy (DBT), rational-emotive behavioral therapy, and exposure-based individual and group therapies.

My current role at the Dayton VA is focused on providing evidence-based treatment to individuals with a severe mental illness (SMI) through the Building Bridges Psychosocial Rehabilitation and Recovery Center (PRRC). Our goal is to provide a supportive setting for individuals who struggle with sometimes debilitating symptoms to begin creating and pursuing goals they may have never imagined for themselves. Our program offers opportunities for individual and group psychotherapy, as well access to evidence-based treatments such as cognitive-behavioral therapy and social skills training to work toward symptom reduction, greater community involvement, socialization, along with fewer, if any, psychiatric admissions. The recovery model utilized is very close to my heart because of my experiences both inside and outside the psychology world. Specifically, one of my passions is working on the mission field, something my wife and I have been a part of for the past 7 years. Through these experiences, both local and abroad, I've learned how important it is for our field to truly understand the impact both culture and diversity can have not only on the individuals we provide services to, but also on a global scale. The world we know is not necessarily the same experience of those around us. I found this to be important as I continue to develop as a psychologist and a person.

Yolanda T. Garmon, Psy.D.

In my professional career, I have worked with adults, senior adults, adolescents, and children. I have provided services in the areas of domestic violence, geriatric mental health, chemical dependency, and community mental health. I currently serve as the Coordinator for the Dayton VAMC Psychosocial Rehabilitation and Recovery Center (PRRC), which is also known as the

“Building Bridges” Program. The Veterans that I serve have serious mental illness and severe functional impairments.

I have found that regardless of my practice setting, most individuals respond well to respect, empowerment, and collaborative treatment planning. It has always been my belief that everyone is capable of learning and growing, and that treatment should be based on a person’s strengths, so it was quite refreshing to learn that the VA is working to implement the recovery model for treatment services. Many of our Veterans struggle with stigma and have received direct or indirect messages that the most they should hope for is to manage symptoms in order to avoid hospitalization. Part of the work we do in “Building Bridges” is deconstructing former notions about treatment. We choose to focus on wellness, and not illness. We believe that everyone can live meaningful lives, and we work to instill hope and build skills that will help Veterans to overcome obstacles in order to assist them in reaching their self-chosen goals for recovery.

Implementation of the recovery model includes the use of evidenced-based practices. I often utilize cognitive-behavioral interventions in my practice. I believe that a person’s difficulties can often be traced back to maladaptive beliefs. In treatment, individuals can learn to identify, challenge, and modify these beliefs—leading to growth-promoting change. Engaging in the examination and behavioral testing of potentially irrational beliefs empowers an individual to take control of his or her own emotions and behaviors. It is my opinion that this also fosters hope, which is essential to the recovery process.

In working with individuals with serious mental illness (SMI), my team and I have also witnessed positive outcomes following the implementation of Social Skills Training, which is an evidenced-based practice for working with the SMI population. This approach uses modeling, feedback, and positive social reinforcement to increase effective use of appropriate social skills, including assertiveness, conversational, and conflict management skills. In our program, we have witnessed Veterans implementing these learned skills not only with other Veterans, but also while on outings beyond the VA campus, which reflects the goal of our program: to help Veterans integrate into the community.

Family Services Supplementary Experience

Description

The Family Services rotation provides the opportunity to engage in family focused evidenced-based practice for the treatment of the seriously mentally ill. It is grounded in the Behavioral Family Therapy (BFT) model (Mueser & Glynn, 1999). This rotation includes opportunities to provide a variety of services to meet the needs of families to promote improved management of the mental

illness and overall family functioning. Interventions include Cognitive Behavioral Conjoint Therapy for Posttraumatic Stress Disorder (CBCT for PTSD) (Monson, 2008), Integrative Behavioral Couples Therapy, (Jacobson & Christensen,1996) family crisis management, family consultation (education about mental illness, accessing care, obtaining support, goal setting, safety planning for what to do in a crisis), Support And Family Education (SAFE) programming for loved ones, short- and long-term psychoeducation based family therapy, inpatient groups, and educational workshops. Skills emphasized will be engagement and assessment with the identified patient and family members, providing education to the family about mental illness, improving communication skills in the family, and teaching effective problem-solving strategies.

In addition to regular supervision on site, this rotation includes the opportunity to participate in national Family Psychoeducation conference calls. Family Services provides the opportunity to interface with multiple interdisciplinary treatment providers from various programs to facilitate improved treatment planning and patient compliance.

Specific intern activities will be determined by intern-supervisor goals, the intern's interests, and prior level of experience, as well as rotation competency requirements. Previous family therapy experience is not required for the rotation. The rotation provides a unique opportunity for the intern to acquire an appreciation of family systems issues that directly impact the successful management of a mental illness. The acquisition of this knowledge can come from multiple sources including didactics with the rotation supervisor, VHA medical center sponsored seminars, readings, interactions with experienced interdisciplinary team members, and clinical work. In addition to clinical duties, the intern is required to complete assigned readings and attend regularly scheduled supervision meetings.

**Although a full Family Services rotation is not being offered at this time, certain learning aspects of the rotation may be made available to interns as a supplement to the PRRC or Mental Health Clinic rotation.

Conceptualization Statement

Rahema Rodgers, Psy.D.

I first discovered my love for psychology in the spring of my junior year of undergrad. I took an introduction to psychology class simply to fulfill a general requirement. I loved the class so much I decided to take another, then another, until I finally changed my major. I knew that as a psychology major I could continue pursuing my lifelong goal (declared at the age of 3) to become a medical doctor. I loved the thought that I could learn about something I was passionate about in the mean time. When it came time to apply for medical school, I went through all the steps. However, going through the motions helped

me realize it was no longer my heart's desire to attend medical school. I prayed, searched my heart, researched my options, and determined I would pursue a PsyD.

Upon entering my doctoral training, I assumed I would gravitate toward a psychodynamic approach, and was excited when I started the intervention series. I also took cognitive behavioral, again to fulfill a requirement. Much to my surprise, cognitive behavioral was the therapy approach that I felt worked the best when helping a person make lasting changes to benefit their mental health. Reluctant to dismiss psychodynamic too quickly, I sought out an opportunity for focused supervision with a supervisor who identified as psychodynamic. I believe this experience further solidified my preference for CBT in treatment, while also enhancing my respect for what psychodynamic offered regarding client conceptualization. At that point, I began to form a conceptualization style in which I looked at the factors from the client's background that have contributed to their current dysfunction. I was very interested in family of origin, childhood experiences, attachment, and relationships with people who played a key role during the developmental years. I felt the CBT approach helped to "dig into" a person's psyche and uncover the underlying issues.

As my training continued, I was exposed to brief solution focused therapy, and crisis intervention. Again these approaches influenced my style of therapy, in that I learned how to identify and isolate issues that were of higher priority to a person's current functioning. This helped me let go of the idea that a therapist must address each and every problem they uncovered before the client could be considered "finished" with a course of treatment. I learned that effective treatment could be time limited and focused on the most distressing issue, and saw that clients could make significant progress on that particular issue in a short time span.

Next I pursued my special interest in family therapy, and was exposed to family systems. This was the final piece of my conceptualization puzzle; it reinforced a belief I already held that the people in the client's household were important influences on the progress of clients, especially with children, but even for adults. The dysfunction was not isolated to the identified client. The family, neighborhood, and greater community were also part of the picture and were also impacted by changes the client made through therapy.

I use my training and expertise to help people with severe mental disability on their path to recovery. I see myself as but an instrument for God to use. I believe my time in the clients lives, be it long or short, is for a purpose.

Neuropsychology

Description

Clinical neuropsychology is concerned with the clinical and psychometric examination and interpretation of cognitive-behavioral aspects of brain functioning. These capacities are assessed using an array of standardized neuropsychological measures that are interpreted with the use of appropriately selected normative reference data. Each examination assists in identifying neuropathological etiology, associated brain regions involved, and the presence and extent of any impaired functions. The examination also reveals well preserved or spared neurocognitive capacities and strengths. The neuropsychological examination is increasingly accomplished within the field through a flexible battery approach to assessment versus a fixed battery approach.

Consultations at the VAMC are received from disciplines across the spectrum of patient care providers with an equally diverse range of consult requests. The diverse array of neuropathological conditions and consultation concerns for which individuals are referred is a significant benefit of training in a medical center setting. Evaluations are performed using either a comprehensive selection of tests and procedures, or with the use of briefer protocols, depending on the reason(s) for referral and the patient's clinical history.

Here at the Dayton VAMC neuropsychological training proceeds through two tracks. The first is a 6 month rotation offered for those who wish to specialize in the field, and are planning to apply for post-doctoral training. The second track is a 4 month rotation. This option is provided for interns not seeking post-doctoral specialization, but who wish to acquire or increase a basic knowledge of the specialty practice by gaining neuropsychological screening experience. While acceptance into the 4 month track is at the discretion of the supervisor, most applicants are typically accepted.

Throughout the 6 month neuropsychology rotation, book chapters and journal articles are provided on various topics (e.g., norm selection, neuropsychological correlates of CNS disease processes, neuroanatomy, neuroimaging, TBI, small vessel disease and other related topics). Flexible supervision time is readily provided over the course of the rotation. Supervision follows an apprenticeship model where the intern is expected to progress from close regular supervision to supervision that is more consultative in nature. Explicit rotation competency requirements are provided at the outset of the rotation.

Supplementary learning experiences in the 6 month rotation are obtained through interactions with Neurology Clinic staff, section meetings and through attending the Mental Health Service's lecture series. Interaction with Neurology Service staff is reserved for those interns who plan to apply for post-doctoral training. There are also opportunities to attend a nearby quarterly neuropsychology conference. There are weekly didactic presentations available to all interns from a variety of clinical disciplines on various topics throughout the internship year.

Conceptualization Statements

Anthony Byrd, Psy. D.

The practice of clinical neuropsychology involves the quantitative and qualitative evaluation of brain functions by measuring and interpreting their cognitive and behavioral correlates, using standardized neuropsychological instruments. Functions are assessed with regard to an individual's cognitive strengths and weaknesses, and are conceptualized within the historical context and myriad means by which brain damage and its cognitive-behavioral residuals may occur. There are various approaches or schools of thought by which neuropsychological assessment can be accomplished. The first step with any approach, however, is to obtain solid foundational knowledge in the relevant subject matter and examination procedures.

This foundation must include an understanding of the basic concepts and theories of assessment and use of normative data. It must include knowledge of "normal" cognition and behavior versus impaired functioning, along with knowledge of associated neuroanatomical structure and function. As differential diagnosis is often a critical issue for combat Veterans who may have suffered blast related head trauma, for example, the parsing of various contributions to brain impairment (to the extent possible) is important in decision making for issues of VA compensation and pension. Consequently, knowledge of the neuropsychological correlates of CNS diseases and injuries is essential. The neuropsychological practitioner must be well-versed in the medical and behavioral risk factors for susceptibility to cognitive dysfunction, and the instruments and normative data used for interpretation of the findings.
My preferred approach to neurocognitive examinations is flexible. I utilize a core group of neuropsychological measures, with supplemental tests as indicated by the reason for referral, the patient's clinical/collateral history, and the individual's active performance during the exam. This flexible approach relies on qualitative and quantitative aspects of patient performances. It allows the practitioner to generate/modify working clinical hypotheses, to make in-process instrument selections (or deletions), and consequently, can afford more specificity in interpreting findings and making more accurate diagnoses and beneficial recommendations.

An additional benefit of this approach is the parsimonious use of clinical time; and it often prevents subjecting patients to unnecessarily lengthy examinations. This latter result is especially helpful with more elderly and/or debilitated patients having multiple medical and psychiatric co-morbidities. This flexibility can help provide for a richer neuropsychological profile, as the battery is constructed to respond to the specifics of patient and referral concerns. It is malleable in responding to modifications in clinical hypotheses during the process of the exam, where a rigidly "fixed" approach may not.

With regard to the neuropsychological write-up, there should be demonstration and clear communication of the neuropsychologist's thinking, as informed by conceptualization of presenting complaints, clinical history, test performance, and any conditions affecting performance. Most importantly, the report of examination findings must directly respond to the consultation's referral concern(s), or should indicate why this is not possible, and provide practical and useful recommendations.

I believe that the practice of clinical neuropsychology must continue to evolve over time, due to the necessity for increasingly (ecologically) valid and efficient appraisals of brain-behavior relationships, changing diagnostic nomenclature, and the likely discovery of biomarkers of dementing diseases. This evolution, I feel, must importantly include moving from a primarily (horizontal) cortico-centric model of test construction and examination, to include a better appreciation for the (vertical) cortical-subcortical axis of contributions to behavior and cognition elegantly asserted by Koziol and Budding (Subcortical Structures and Cognition, Springer, 2009). These considerations can be beneficial by promoting innovation in neurocognitive examination models and clinical procedures, in keeping pace with advances in neuroscience and neuroimaging.

Paula G. Daugherty, Psy.D.

I have essentially been practicing Neuropsychology since 1989, starting with Internship to Post Doc to an independent professional. Neuropsychology as a profession as well as a science has certainly grown and evolved these past 20 years and by necessity will continue to do so. I find these times in our profession as exciting and exhilarating especially for those just entering the field. A significant amount of my professional life has been dedicated to the teaching and training of individuals entering the field of psychology. I feel that training and research are two major ways to contribute and "give back" to the profession.

In one of Muriel Lezak's earlier works she describes Neuropsychology as an applied science concerned with the behavioral expression of brain dysfunction. While this profession certainly evolved out of the need to aid the clinicians in the neurosciences with neurological diagnosis, documentation of the course of brain disorders as well as the effects of neurosurgery and other treatments, this is only a partial aspect of the practice of neuropsychology today. This field is open for the traditionalist as well as the professional who takes a broader view of their role. I have had the opportunity to practice and function in various settings such as an epileptic neurosurgery clinic, rehabilitation medicine, medical consult service, head injury re-entry program, research with traumatic brain injury and forensic neuropsychology with the SMD population. I would certainly encourage anyone interested in neuropsychology in their pursuits. It is a profession evolving and changing rapidly with new developments always on the horizon.

Posttraumatic Stress Disorder Program

Description

The PTSD Program consists of two arms: Outpatient and Residential. Referrals to this program come from all over the hospital as well as from other VA Medical Centers and Vet Centers. Unless a Veteran is experiencing more prominent symptoms of another diagnosis that would be better treated in the Mental Health Clinic, Polysubstance Rehabilitation Program or another program, a diagnosis of PTSD is sufficient for assignment to this program. Most Veterans enter this program after an evaluation and review of their DD-214, which highlights benchmarks of their military service. Treatment for PTSD is not limited to war zone related traumatic stress.

The PTSD Clinical Team (PCT) provides evidence-based, recovery oriented outpatient treatment for Veterans and consists of an interdisciplinary treatment staff including psychologists, social workers and a psychiatrist. Interdisciplinary collaboration and treatment planning allows psychology interns to build consultative skills. There are currently three phases of treatment: 1) Motivation enhancement/psychoeducation; 2) Trauma Processing; and 3) Aftercare. We are currently working on adding a fourth phase to include Peer Support among the services offered. Group protocols offered include: Anger Management, Cognitive Processing Therapy, Nightmare Resolution, Relaxation Training, and consumer driven Support Groups. Individual therapy frequently includes EMDR, Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), and Cognitive Behavioral Conjoint Therapy (CBCT) for PTSD.

The Residential Treatment team provides services to Veterans with more severe symptoms who reside in the Mental Health Residential Rehabilitation Treatment Program (MHRRTP). The program has the capacity for up to 15 Veterans, enrolling in an 8-week program that offers individual therapy, group therapy, recreation therapy, chaplain services and groups, and medication management. The residential program accommodates Veterans dually diagnosed with substance use disorders. Staff include: psychologists, an addiction therapist, social workers and social science specialists.

Conceptualization Statements

Deborah L. Downey, Psy.D.

Traumatic experiences can have a shattering effect on clients' sense of self, their emotional stability, and worldview. Because trauma can negatively impact all aspects of our clients' identity and ways of relating to others and their

environment, I approach clients in the PTSD residential treatment program in a holistic way.

Of course, good treatment begins with a thorough evaluation, and a variety of assessment instruments (e.g., semi-structured interview, PTSD instruments, other psychiatric screening instruments) are utilized. My basic case conceptualization and treatment approach is based in cognitive-behavioral theory with special attention to individual client characteristics such as gender, race, age, sexual orientation and the like. Additionally, I am familiar with and incorporate elements of humanistic, existential, Adlerian and other individual and systemic therapies into treatment as dictated by client need. Treatment is provided individually and in group formats.

My treatment approach is also team-based, out of necessity but also by preference. PTSD residential staff works closely with Mental Health Clinic, substance abuse, psychiatric and domiciliary staff, as well as others throughout the medical complex. Our mental health team and other VA service providers are a mix of professionals with unique personalities and professional strengths, and we all collaborate to serve our Veteran clients. A collegial attitude, compassion for others' suffering, willingness to be flexible, moral and ethical practice principles, and sense of humor help facilitate the day-to-day give and take of a busy, demanding service schedule.

Our goals in PTSD residential are to measurably decrease patient suffering and distress, and to increase clients' level of functioning upon return to the community. Basic beliefs in the fundamental worth and dignity of each individual we serve are imperative. A nonjudgmental attitude, willingness to challenge dysfunctional beliefs, and teaching, leading, and coaching clients toward psychological health are key to our success in obtaining treatment goals.

Finally, I want to say that in keeping with a holistic approach to treatment I believe that we as mental health specialists need to take care of ourselves. We need to actively maintain balance in our own lives – psychologically, physically, socially, and spiritually. We need to continue learning and growing professionally and personally so we can nurture and inspire those with whom we work.

Maria Noce, Psy.D.

My work at the Dayton VAMC takes place across the Post-Traumatic Stress Disorder Outpatient and Residential Program and collaborates with the Substance Abuse Programs, as the PTSD-Substance Abuse psychologist.

The overarching philosophy of my training background and practice style is one where the multidimensionality of the person is paramount, not like a jigsaw puzzle that needs to be "figured out," but much like a pointillist painting that requires us to stand back with perspective to appreciate the whole portrait. As

such, I tend to be flexible and integrative in both theoretical conceptualization and treatment technique. Specifically, I have been trained in and tend to utilize Cognitive-Behavioral Therapy, Humanistic/Existential, and Strategic approaches with other evidence-based treatments specific to Veteran Recovery from PTSD and substance use disorders (e.g. Cognitive Processing Therapy, Dialectical Behavior Therapy Skills Training, Motivational Interviewing, Prolonged Exposure Therapy).

I believe good practice is truly a blending of the science and art of psychology. The work of Jerome Frank and Bruce Wampold are particularly influential in how I understand the nature of the change process at its core. Psychotherapy is a cultural healing practice; meaning healing or *change* occurs not because of a specific "ingredient," or because a particular treatment protocol has specificity for a certain diagnosis, but because of the *context* in which treatment is delivered. Essential and effective elements that I try to target in any theoretical approach include alliance, elucidating the patient's understanding of his/her distress, providing an augmented rationale or meaning for the patient's distress that coincides with the cultural context, and providing interventions that naturally fit this rationale and the patient and I believe in.

My work with Veterans recovering from PTSD and substance use disorders is continually challenging, yet also continually amazing in witnessing the resilience of those who have served our country. This professional path affords its travelers the opportunity for constant learning and growth along with the Veterans served. It is a path where I am continually challenged and receive personal reward.

Kristin Rodzinka, Ph.D.

My role at the VA has grown and evolved such that I frequently am found wearing multiple "hats". I absolutely love the mission of VA and the opportunities this large system has offered to me. Since January 2011, I have been serving as the Acting Coordinator of the PTSD Programs in addition to my permanent role as the Military Sexual Trauma (MST) Coordinator for this facility. I am also a Co-Director of Training for the Psychology Internship Program. I am actively involved in the national VA Psychology Training Council and am a member of the VISN PTSD Experts workgroup.

My job provides me with a variety of administrative and supervisory responsibilities as well as the opportunity to work with individuals with a wide range of functioning levels, diagnoses, and mental health needs. I work primarily with combat Veterans and individuals who have experienced military sexual trauma including Veterans with PTSD, psychotic disorders, mood disorders, other anxiety disorders, traumatic brain injury, personality disorders, substance abuse and medical health issues.

My professional development really began when, as an undergraduate, I was compelled to change my Business major to Psychology and Women's Studies. I found that a compassionate and humanistic approach, validating diverse experiences, resonated with my values. I became involved in a domestic violence project and continued my own sexual assault trauma research in graduate school. I have made multiple presentations at national APA and AABT/ABCT conventions and had opportunities to learn from leaders in Cognitive and Cognitive-Behavioral therapy and research, particularly in relation to trauma and mood dysfunction (Foa, Resick, Beck, Ellis).

Prior to coming to the VA in 2007, I had seven years of experience working in community mental health with a diverse, complex, and high acuity patient population. I believe in a recovery based approach and evidence based practice. I believe that training in Empirically Supported Treatments is necessary but alone is not sufficient. I have a strong Cognitive-Behavioral theoretical orientation that influences my case conceptualization and treatment interventions. That stated, I have found ESTs to be most effective when a good fit and the Veteran has adequate skills and readiness to engage in them. Particularly when working with individuals with extensive trauma histories and complicated mental and medical health issues, comprehensive and ongoing case conceptualization and multifaceted treatment approaches are a necessity.

I believe that change requires motivation, skills, and support. I use an interpersonal approach and value nurturing positive therapeutic relationships to create opportunities for implementing effective interventions. Much of my current approach to treatment is influenced by my experience using the DBT model (Linehan, 1993) and Cognitive Processing Therapy for PTSD. I have witnessed remarkable transformations in people who other providers had deemed unmanageable and untreatable. I am also trained in Prolonged Exposure Therapy for PTSD and find it to also be highly effective.

Particularly when working with folks with lower functioning levels, I find that thoughtful modeling of and self disclosure about coping strategies and interpersonal skills is very useful. I have extensive group therapy experience (I stopped counting after 1000) and have found it can be as effective as or more effective than individual therapy for some people as groups offer opportunities for validation and normalization that a therapist alone cannot provide.

I work to maintain a mindfulness-oriented approach to psychotherapy as well as life in general. I use a biopsychosocial model to inform my case conceptualization. I believe in striking a therapeutic balance between acceptance and change oriented interventions. I am very open to borrowing techniques from multiple approaches and adopt a "do what works" attitude when working with patients. I have found that when using evidenced based treatments it is imperative to remember that one size does not fit all and creativity and flexibility are necessary to meet patients where they are at.

I think that case consultation and supervision (both formal and informal) are essential for developing good clinical skills. This is a process I greatly enjoy.

Roger Schmidt, Ph.D.

Although patients seek treatment to “fix” particular problems, essentially they are looking to be heard, understood and validated. Many people come to the therapy experience dispirited because they want to connect with others but find it difficult to do so which often results in a range of difficulties. Therapy provides an opportunity to expand the skills necessary to develop these connections. At the outset of therapy, frustration and discouragement dominate the accounts people have of their presenting problems. I see one of my initial tasks in therapy as helping patients re-conceptualize their “problems” in a more hopeful fashion.

I strive to “sell” individuals on the power and potential of working collaboratively. Collaborative interactions increase the chances that patients will continue to seek therapeutic guidance and support until they have acquired the skills to function more fully. I frame my role in the collaborative alliance as part coach, guide, and teacher. The cornerstone of the work I do with patients is humanistic in that I see the therapeutic relationship as the foundation for all other therapeutic tasks. The art of therapy lies in engaging people in ways that instills hope and courage, and incrementally, allows for the development of skills that facilitate lasting change.

My therapeutic orientation is driven by two components: a contextual domain and a technical domain. The contextual domain centers on developmental considerations, learning principles and need theory. Through thoughtful assessment (conducted throughout the course of treatment) and discussion, I want to uncover pertinent developmental considerations, learning histories, past trauma and abuse, and the assets that individuals possess (but may not be aware of). A resiliency and protective factors framework is fundamental to my theoretical orientation

The technical domain relates to the “science” of psychotherapy. Research increasingly informs practice as evidence accumulates in the area of empirically-supported treatments. While cognitive behavioral therapy (CBT) is a very active form of therapy, it is not just a "talking cure." I prefer CBT because it is a proactive, empowering form of intervention that fits an "evidential" theory of behavior change. In CBT tradition, when patients perform personal experiments, they can accumulate positive results that speak to their growing competence.

My conceptualization of cases is driven by a need to understand the patient’s internal working model. I want to know how they make sense of the world and their place in it. I want patients to help me understand their core beliefs because I think they hold the key to unlocking the points of reference that patients use to measure all subsequent experiences.

In the context of these guiding templates, I provide treatment which ideally involves a few core tasks. I want to educate the patient about their clinical problem(s). I want to ensure they have coping skills to manage difficult situations. I want to facilitate an optimistic re-conceptualization of current problems such that the patient sees problems as obstacles that can be overcome. In the interest of developing competencies, I also want the patient to take credit for the changes they are bringing about by “doing the work” in therapy. I want them to see the connections between their efforts and the resulting positive changes. Finally, I want to conduct relapse prevention in ways that allow the patient to anticipate risks, recognize “warning signs” of problem development, and be able to engage effective coping skills.

Audrey L. Smith, Psy.D.

At the core I am client-centered. I believe, as DiClemente and Prochaska confirm, that the therapeutic alliance is the engine that drives a therapeutic process. To this I add specific techniques based upon a thorough assessment of the client and their presenting concerns. I believe it is essential to understand the worldview, the internal and external resources, along with the internal and external barriers to change for each client served. I highlight client strengths and believe in a recovery model. Intrinsic capacities and drives must be matched with new learning, biological, psychological, social and spiritual interventions (holistic supports) that enhance steps toward recovery. The theoretical orientations that most impact me are existential, cognitive and behavioral.

Of the existential camp, one author who has impacted me since undergraduate study is Clemmont Vontress. His models often refer to cross-cultural therapy, and he indicates that we all live within unique, overlapping layers of culture, which leads to any dyad as crossing cultures. Vontress emphasizes assessment of the embedded systems within which individual’s function, from intrapsychic styles, to families, communities, societies, and the culture, traditions and beliefs of one’s view of Universe and spiritual overview for life. He emphasizes having great respect for the multiple layers impacting one’s functioning, one’s phenomenology and one’s existence. From knowing oneself and gaining “over-standing” of another, interventions can be designed that are organic to the therapeutic alliance and to a client’s motivation for change and success.

Another framework from which I operate is William Glasser’s Reality Therapy. This theory recognizes that humans will meet their basic psychological needs for power, freedom, pleasure, procreation (legacy) and belonging, to which I add needs for esteem and meaning. Therapy can help clients make these needs and methods of meeting needs conscious, efficient, and healthy. To effectuate these existentially-bent theories, cognitive and behavioral methods are quite useful.

In the PTSD Clinical Team, the outpatient arm of this program, we see primarily combat trauma and military sexual trauma, although childhood abuse and neglect and other trauma experiences are not uncommon. This work requires thorough assessment of the individual and the ability to distinguish diagnostic criteria. It also involves collaborative treatment planning, and facilitating individual and group psychotherapy. The Clinical Team is inter-disciplinary, and collaboration is useful toward a holistic approach and providing multiple resources for treatment.

Traumatic stress powerfully embeds beliefs about oneself and the world that must be examined and accommodated or deconstructed. I view the biological/neurological dysregulation that follows trauma as an intrinsic effort to heal and digest powerful stimuli. For example, re-experiencing represents the mind's effort to process, make sense of and properly store memory. Therapeutic exposure can allow that natural function to happen in an orderly and safe fashion. Arousal is the nervous system's attempt to complete the loop of sympathetic and parasympathetic regulation. Behavioral training for relaxation and self-control, paired with arousal generated in mental triggers, allows this circuit to close. Anger, as a motivation to restore justice, regain power, and balance expectations, is harnessed and redirected, if understood as a healthy function gone awry. Avoidance, as a self-protective measure, can be reduced once an individual's sense of personal power, over self and surroundings, is up-regulated.

In the PTSD Program teaching and reinforcing healthy behaviors and boundaries, along with reducing isolation through social-support building, are key components to recovery. Evidence-based approaches such as Cognitive Processing Therapy, EMDR and Relaxation Training and Prolonged Exposure are used to address each of the symptom clusters of Posttraumatic Stress. As PTSD symptoms ameliorate, clients are empowered to redefine and refine their beliefs and make meaning of their experiences. Whenever appropriate for my clientele, I seek to accomplish this by exploring cognitions related to existential questions, personal worldviews, and by offering training in approaches to meeting their basic psychological needs.

Substance Abuse Treatment Program

Description

This rotation involves the provision of psychological services to Veterans Polysubstance Rehabilitation and Dual Diagnosis. It consists of a multidisciplinary treatment team. Services typically include assessment, individual psychotherapy, group psychotherapy, psychoeducational groups, and psychosocial skills training. The majority of these services are provided in the residential programs with the option to continue treatment on an outpatient basis once Veterans are discharged from their respective programs.

The Substance Abuse Treatment Program rotation allows for a considerable amount of flexibility to meet an intern's specific professional interests and needs. Interns have the opportunity to work with complex patients whose diagnoses include, but are not limited to, the following: substance-related disorders, psychotic disorders, mood disorders, anxiety disorders, sleep disorders, impulse control disorders, adjustment disorders, and personality disorders. Considerable emphasis is placed on the assessment and treatment of substance abuse/dependence.

Conceptualization Statements

Peter Herr, Ph.D.

As you look for an internship my hope is that you find one that fits your interests, but also provides you with useful experiences that expands your ability to understand your clients and stretches your skills and self-concept. My view is that without experience working with substance dependent clients and their families we can not be fully prepared psychologists. Drug and alcohol dependence continues to cause untold human physical and mental suffering and billions of dollars in lost wages, legal expenses, and medical costs. Whether you have an interest in forensics, health psychology, PTSD, or chronic mental illness, it will be important to understand addictions and their effect on you, as well as your clients.

The focus of the Polysubstance Rehabilitation Program rotation will be working in a residential setting as part of a multi-disciplinary team. You will have opportunity to assess Veterans, lead groups, provide education, do some testing, and provide brief, focused, individual therapy. Our Veterans have legal issues, pain issues, PTSD, personality disorders, and serious and chronic mental health disorders. (Complicated? Yes. But isn't that what you signed up for?) Your experience will be varied, challenging, and rewarding individually and professionally. And while this rotation will only give you a taste of the work it will be a start and useful regardless of what direction you pursue.

I have worked with substance dependent clients on and off for over 20 years and practiced in a state hospital, mental health clinics, a women's prison, and here at the V.A. My interests continue to be substance dependence, chronic mental illness, group therapy, organizational development, CBT and Psychodynamics, and shame and its relationship to anger. My desire is to share my experience and knowledge as you move towards fulfilling your goal of becoming a psychologist, to provide a useful and rewarding internship experience, and to learn from you. Good luck in your application process.

Monica Jackson, Ph.D.

My journey in psychology began as an undergraduate. Initially a political science major, I decided to switch to psychology for the same reason so many of us have…to learn more about why people do what they do. I found human behavior and emotions to be fascinating and intriguing. My beliefs about how people work is quite simple. People want to be happy. People sometimes don't know what that means for them. People sometimes don't know how to become happy. People sometimes don't want others to be happy. I have found that for the most part, we all want what we want, when we want it. We would prefer not to have rules and we would prefer that everybody like us and applaud everything we do. Now, the more mature of us, recognize that is not realistic and we go on to learn how to live out the Serenity Prayer. For some of us, that is not the case. We fight and fight against ourselves, others, and the reality of the situation we find ourselves in. The battle is fought via depression, anger, anxiety, guilt, grief, and so on and so forth. As a psychologist, my job is to assist people in untangling themselves from the battle, getting out of their own way, so that they can let "happiness" find them. I have found cognitive behavioral theories and psychodynamic theories to very useful in my practice. I find cognitive behavioral practices to be most in line with what I believe about people. Change the way you think and behave. How you think about a situation is half the battle. How you choose to respond to that situation is the other half.

Geropsychology Rotation

Description

The Geropsychology rotation at the Dayton VA Medical Center provides the intern with experience in geropsychological services across a continuum of care, including home-based prime care for those still able to live at home alone or with a loved one, nursing home care for those who require more assistance and supervision, and hospice/palliative care for those who are at the end of life. Services are, therefore, provided in a variety of settings which include Veterans' homes, the VA's Rehabilitation Unit, Community Living Center (i.e. Nursing Home), Skilled Nursing Home Unit, and Hospice/Palliative Care Unit. This continuum of services potentially allows an intern to follow older adults between levels of care as their needs change with the aging process, thus providing a broader perspective on the interface between a geriatric patient and the healthcare system over time.

The rotation offers the intern a wide variety of assessment, intervention, and consultative experiences involving the care and treatment of geriatric patients within the context of an interdisciplinary team approach. Specific intern activities will be determined by intern-supervisor goals, the intern's interests and prior level of experience, as well as rotation proficiency requirements (which incorporate standards from APA's "Guidelines for Psychological Practice With Older Adults"

as well as competencies from the Council of Professional Geropsychology Training Programs/Pikes Peak Model). Previous geropsychology and neuropsychology experience are not prerequisites for the rotation. Examples of professional psychology activities include: individual, group, and family therapy; psychological/emotional, grief, decisional capacity, and cognitive assessments; attendance at family and treatment team meetings; and other psychological services aimed at addressing the developmental, cultural, and diverse needs of this population. The intern will work with the rotation supervisor(s) in responding to consultation requests and providing pertinent oral and written feedback to staff, as well as to patients and families, as indicated.

The rotation provides a unique opportunity for the intern to acquire an appreciation of issues impacting an aging population, such as: dementia, delirium, cognitive changes, spirituality, adjustment/emotional reactions to functional decline, loss, late life psychiatric conditions, and death/dying. In addition to clinical duties, the intern is required to complete assigned readings and attend regularly scheduled supervision meetings.

Conceptualization Statements

Nicole A. Best, PsyD

Although true with clients of any age, culture, gender, or health status, it is especially important when working with geriatric and medically ill individuals that a bio-psycho-social-spiritual model be the foundation of any theoretical conceptualization. We are all spiritual, physical, mental, and social beings who are constantly and simultaneously functioning at each of these levels.

Over and above this basic foundation, an appreciation for the role of grief becomes essential when working with a geriatric population. Whether terminally ill, residing in a nursing home, or continuing to function in the community, aging brings multiple losses and raises core existential questions. It is a time when many individuals have a need to review the story of their life, and to find meaning in past trials and triumphs, as well as in current illnesses and suffering. It is for some, the first and last time they will contemplate their place in the universe, their relationship with God, their life’s mission, and whether they believe they have reached a satisfactory conclusion.

Issues of faith and spirituality are often at the forefront of my patients' minds and consequently, often take center stage in therapy sessions. In addition to an ever-present vigilance regarding boundaries of professional competence (i.e. knowing when to involve a chaplain), a psychologist must be equally aware of the fact that some patients do not feel comfortable talking to a clergy person, that most ministers are not trained counselors, and that the role a properly educated psychologist can play in this area can be pivotal in the lives of the patient and their family.

Working with individuals at this stage of their life's journey necessitates a solid common factors approach, grief work, and an ability to be flexible (eclectic) in interventions based on the client's presenting issues, personality, belief system, cultural background, cognitive abilities, and readiness for change.

Although continually evolving, much of my inspiration at this point in my own professional development, comes from the works of countless psychologists, physicians, philosophers, and theologians who are dedicated to the research, exploration, and integration of psychology and spirituality (e.g. Harold Koenig, Robert Roberts, Paul Vitz), the grief and end-of-life literature (e.g. J. William Worden), the Common Factors data (e.g. Hubble, Duncan, Miller); as well as my own faith, and lessons learned from the best teachers of all – dying patients whom I have had the privilege to know.

Linda DeShetler, Ph.D.

I feel privileged to offer psychological treatment with patients in the Home Based Primary Care Program (HBPC). By way of background, HBPC is a new national VA initiative wherein patients who are medically fragile and unable to come into the hospital or a primary care office for treatment, are offered services in their home from the treatment team. As a clinical psychologist on the team, I receive referrals for psychological evaluations, cognitive assessments, decisional-capacity examinations, suicidal evaluations, individual and family psychotherapy, behavioral assessment/management etc. Certainly many, but not all of the patients I treat are in the geriatric age range. Within this age group (more so than among younger aged populations) there are greater differences among individuals. Differences in cultural background, life experience, personality, education, faith and belief systems, current and past medical history, and interpersonal dynamics with others, as well as offering treatment in the home environment adds to the uniqueness of each person and also to the complexity of a thorough evaluation and holistic conceptualization. For me, the writings of Adler, Rogers, Engles, Meichenbaum, Fabrega, and Beck, as well as the Health Belief Model contribute to a holistic, biopsychosocial conceptualization and treatment approach. Please allow me to explain how my conceptualization evolved.

My conceptualization has been shaped in part by my own academic and professional experiences. Prior to becoming a psychologist, I received an MA from The Ohio State University and was licensed as a Professional Supervising Clinical Counselor. It was through this early foundation that I began to appreciate Rogers' and Adler's validation of individuals' perceptions of their life experiences. I especially drew upon Adler's theory when working with patients who felt trapped by their circumstances. His theory offers the hope that individuals are not passive recipients of their genetic heritage, (and I would add, medical condition) or the environment. He believes (as do I), that all persons have choices, and to a large

degree, are responsible for the goals and decisions each makes in their own life. For me, this meant not only imparting this hope with my patients, but living this out from a personal perspective as well.

While working on my Ph.D., I continued to work in a hospital setting. What a benefit to integrate my doctoral coursework in clinical psychology while in treating (primarily) inpatients. The Health Belief Model provided a paradigm to understand how individuals form health perceptions and health beliefs and how these in turn impact choices and decisions regarding current and future health behaviors. Additionally, while I had a previous familiarity with Cognitive Behavioral Theory (CBT), I found (through the mentorship of two particular supervisors) this theory to be especially helpful in working with an interdisciplinary team. As well, CBT could offer patients a measure of control over their lives when faced with loss, change, and uncertainty due to medical, relational, or other types of situations.

Certainly as medical issues and health concerns take a forefront role in Veterans' lives, there may be a need to rely upon significant others for caregiving aid. There may be memories or forgotten traumas that return. Some individuals wish to make a life review; others draw upon or question their faith, particularly when new diagnoses surface. There may be cognitive decline due to dementia, or mental status changes, or behavioral changes which require an exploration of antecedents. Our Veterans have a lifetime of history, memories, relationships, hopes, and fears along with medical illnesses. I count it a privilege to be able to participate in the sharing of their life stories; to aid in assessing what might be the cause of change in mental status, behaviors, or mood; to discover the patient’s strengths and values in order to align these with their goals; and/or perhaps to offer grief psychotherapy as one sorts through issues of faith. As Fabrega (1996) reminds, it is through the patient’s culture that illness is shaped and given meaning. By understanding an individual's culture, values, and strengths, an internal sense of control can be attained. Self-efficacy is realized, one's functional level is improved, and the future can be more hopeful for the Veteran.

Patricia A. Perry, Psy.D.

The main areas of clinical practice that I have worked in have been community mental health and geropsychology. These areas have influenced my theoretical orientation, choice of intervention tools, and my view of self as a member of an interdisciplinary health care team. In community mental health I have worked in a day treatment program, and in outpatient clinics (e.g. sexual abuse recovery, vocational counseling). I have worked within all levels of long term care, from independent living on a retirement campus, to assisted living and the nursing home. My work has most often been with the lower socioeconomic status, underserved clients in the community.

As a psychologist, I would describe my theoretical orientation, i.e., how I conceptualize a client's problems / circumstances, as interpersonal or dynamic. My intervention strategies are eclectic and integrative, depending on a client's needs and ability to learn and change. I value a comprehensive assessment, i.e., a bio-psycho-social-spiritual evaluation, to provide a firm foundation for establishing Axis I – V diagnoses. Furthermore, I want to ensure that each treatment plan addresses Axis I and II (as is appropriate) diagnoses, and is collaboratively discussed with clients in an understandable and straightforward manner. Lastly, I believe in and regularly seek consultation with members of the interdisciplinary team for their contributions to problem solving.

In general, I want to educate a client to better understand his / her problems in functioning, to empower so that he / she can be a more active member of the health care team, to increase awareness of how his / her interpersonal functioning informs coping, and to promote use of existing skills and strengths as well as acquisition of new, positive behaviors.

In long term care settings, I see three therapeutic roles for the psychologist: 1) to assist the client both in the initial transition from community living to long term care campus life, and within levels of care (independent living to assisted living to the nursing home); 2) to help the client understand his / her health issues including functional losses / adaptations; and 3) to encourage the client to maintain the highest quality of life, especially in regard to relationships with family, friends, other residents, and God. As individuals experience the multiple losses of this stage of life (e.g., driving, home ownership, loss of partner / spouse, decisional capacity), the psychologist can be a skilled professional presence and a powerful ally in processing change.

In conclusion, geropsychology is especially exciting to me for several reasons. It is one of the growth areas of psychology, as the population continues to age. In a zeitgeist of brief therapy, this specialty offers a unique opportunity to form a trusting therapeutic relationship, potentially lasting many years, that promotes ongoing development and adaptation. (The average length of stay in nursing homes nationally is 7 years.) This specialty has allowed me to learn one-on-one from the previous generation about changes in culture, life, and values, as well as our place in time. It is both ironic and fitting that working in this specialty has enriched and informed my work with clients of every age.

ADDITIONAL TRAINING EXPERIENCES AND SUPPORT

Training Seminars

There is an ongoing didactic series throughout the internship year. The meeting time is each Monday, 2:00pm – 4:00pm. The subjects and presenters are quite varied. Intern attendance is mandatory. We also participate in a collaborative

with Wright State University's School of Professional Psychology and Wright Patterson Air Force Base APA accredited internship programs. Several times each year we coordinate shared didactics taking advantage of the strengths and unique aspects of each program and providing opportunities to spend time with interns from other local programs.

Group Supervision

Each Monday, 1:00pm – 2:00pm, is group supervision. The general approach is to augment supervision taking place in other settings and to provide a venue in which interns can support their mutual professional development. Both interns and training supervisors present cases for consultation providing a venue to discuss in depth diverse and complex cases. Interns are expected to participate as consultants to the presenter to help develop case conceptualization and supervisory skills. Specific subjects are quite varied: case presentations, diversity discussions, evidence based psychotherapy discussions, concepts/theories, etc. Intern attendance is mandatory.

Testing Laboratory

Medical records are fully computerized including access to a wide variety of personality inventories, self rating forms, etc. We maintain regularly update an extensive selection of noncomputerized psychological tests and neuropsychological instruments. (See also the Assessment Requirements listed above.)

Library

The Health Sciences Library houses many volumes of professional books and subscribes to over 300 professional journals. Immediate access to a wide variety of online electronic journals is available. Staff are experts in completing literature searches and obtaining copies of articles and borrowing books from other institutions. Also, the library has an extensive collection of audio, video, and microfilm holdings.

Medical Media

Medical Media is available to assist the hospital staff with a variety of services including photographs, graphic art, and video production. The staff are quite helpful with teaching and the development of presentations.

Professional Development

An intern will be given 24 total hours of authorized absence during the training year. This time can be used to attend professional presentations, conferences,

workshops, and organizational meetings that are consistent with professional development plans. This time can also be applied in support of dissertation related activities such as trips to the university, oral defense, etc. In addition, interns are provided with a four hour block of time each week for the purpose of dissertation work or other approved scholarly work. Finally, each intern is encouraged to make use of the many educational presentations within the medical center and the surrounding academic community.

PHYSICAL SETTING AND SUPPORT

Primary intern offices are located in the Mental Health Clinic on 7N of Building 330 (the Patient Tower). Each intern has an individual workstation (computer connected to the mainframe) along with a telephone that has voice mail. Several other psychologists are located on the unit. A conference room and two group rooms are part of the unit as well. Rotations located away from the Mental Health Clinic have additional office space, including computer access, for any intern whose is on that rotation for seeing patients and completing paperwork.

Medical records are electronic and almost all of the professional activities are accomplished through use of various computer programs. The first two weeks of the academic year are devoted almost entirely to orientation and training. Within a few days of arriving, each intern has full computer access and is able to engage in the full range of psychological services. Standard programs include the Computerized Patient Record System (CPRS), psychological tests, Microsoft Outlook, Microsoft Word, Microsoft Windows, Excel, Power Point, and Internet access.

APPLICATION

Eligibility

It is important to note that a CERTIFICATION OF REGISTRATION STATUS, CERTIFICATION OF U.S. CITIZENSHIP, and DRUG SCREENING are required to become a VA intern. The Federal Government requires that male applicants to VA positions who were born after 12/31/59 must sign a Pre-appointment Certification Statement for Selective Service Registration before they are employed. It is not necessary to submit this form with the application, but if you are selected for this internship and fit the above criteria, it will be required. All interns have to complete a Certification of Citizenship in the United States prior to beginning the internship. We will not consider applications from anyone who is not currently a U.S. citizen. The VA conducts drug screening exams on randomly selected personnel as well as new employees. Interns are not required to be tested prior to beginning work, but once on staff they are subject to random selection as all other staff.

All applicants must be enrolled in a clinical or counseling psychology graduate program that is accredited by the American Psychological Association. We require that all academic requirements, other than dissertation, be completed prior to the beginning of the internship year. We prefer prospective applicants be sufficiently advanced with the dissertation so that completion can be anticipated by the end of the internship year.

All applicants are expected to have psychological assessment and testing experience including the administration and interpretation of Objective Personality Assessments and standard IQ measures.

The VHA Medical Center, Dayton, Ohio, maintains a policy of equal employment opportunity in intern recruitment and retention. All recruitment processes are consistent with existing federal laws, guidelines, and policies. As such, it is possible that applicants with Veteran status may be given preference for consideration to interview.

Appointment and Benefits

Technically, each intern receives a one to three year temporary appointment per Department of Veterans Affairs regulations. The type of appointment allows us to provide the same benefits offered to any regular employee including health insurance.

The internship year will begin on Monday, August 29, 2011. The total number of hours is 2,088 to include established holiday leave, annual leave, and sick leave. Annual leave and sick leave are accrued at a rate of four hours per pay period. We are not authorized funds to purchase unused annual leave at the completion of internship. Sick leave can be accrued and maintained "on the books" indefinitely and may be used if one becomes a federal employee at some time in the future. For the purpose of state licensure, our procedure is to verify the usual and customary 2,000 hour internship. The pay is $24,410 for the year to be paid in equal installments over 26 biweekly pay periods.

As a federal employee, drug screens and background checks are routine. Prior to the actual appointment, a matched applicant must complete the appropriate paperwork and complete a physical examination that certifies s/he is capable of the duties required. The Department of Veterans Affairs, and consequently this medical center, adheres to the Americans With Disabilities Act and will provide reasonable accommodations for an individual who informs us that s/he has a disability.

The official appointment as a Psychology Intern is contingent upon successful completion of practica and academic requirements (other than dissertation) along with continued professional conduct consistent with quality practice of psychology.

Application Procedures

Our primary source of information is the Online AAPI. We additionally require all applicants to include an Interview Dates and Rotation Preference paragraph in the cover letter to facilitate our interview process. This additional information is included at the end of this brochure and can be cut and pasted into your cover letter. We adhere to the Association of Psychology Postdoctoral and Internship Centers (APPIC) guidelines for the recruitment and selection of psychology interns including the policy that no person at this training facility will solicit, accept, or use any ranking related information form any applicant prior to Uniform Notification Day.

To apply you must complete:

APPIC Uniform Application (AAPI), available at www.appic.org.

Interview Dates and Rotation Preferences paragraph (unique to our site). This should be included in your cover letter.

The deadline for receipt of application materials is November 10, 2011. Please follow APPIC instructions and guidelines for completing and submitting the AAPI.

Our procedure is to review each qualified application in detail and invite 25-28 applicants for interviews. The customary agenda is for the applicants to meet with the Chief of Mental Health and Directors of Training as a group. Each applicant then meets with three different supervisors who, as much as possible, are chosen based upon rotation preferences. Applicants meet with current interns as a group in a non-evaluative information sharing meeting. Finally, there is a general meeting among all applicants, supervisors, and current interns. We encourage applicants to become familiar with our staff and setting to assist in their decision making process. We try to schedule no more than seven applicants per interview day. Our practice is to rank those applicants who attend interviews for the purpose of the match. Only in rare circumstances would an applicant who is interviewed not also be ranked. Applicants who are invited for interviews but do not attend will not be ranked for the match.

If you are unable to be present for your scheduled interview date, we may be able to accommodate some adjustments in scheduling (although this is not guaranteed). We do not provide phone interviews.

Scheduled interview dates are:

Wednesday, January 4, 2012, 8:00am – 12:15pm

Friday, January 6, 2012, 8:00am – 12:15pm

Tuesday, January 10, 2012, 12:00pm – 4:15pm

Thursday, January 12, 2012, 12:00pm – 4:15pm

DIRECTIONS TO THE VHA MEDICAL CENTER DAYTON, OHIO

Interstate road 70 runs east-west a few miles north of Dayton. Interstate road 75 bisects Dayton in a north-south direction and US 35 bisects Dayton in an east-west direction. The VHA Medical Center is on the west side of Dayton. Visitors are advised to use US 35 west from the I-75 / US 35 interchange. Take US 35 west to Liscum Drive (second traffic light). The medical center is on the right. The Patient Tower is the largest and tallest building on campus (with a nine story patient tower). If you need further directions, lodging information, or have other questions, please feel free to contact us by telephone or email. Also, a map can be obtained on the Dayton VHA Medical Center Web Site at http://www.dayton.va.gov/.

Our main offices are located on the 7th Floor, in the Mental Health Clinic on 7N in the Patient Tower (Building 330). Parking is free throughout the medical center and ample parking is available on the south and west sides of the Patient Tower – though please be prepared to walk a distance.

MATCH DAY

The official dates for the 2012 – 2013 academic year are posted by APPIC at:
http://www.appic.org/match/5_2_match_about.html

Early February 2012: Deadline for submission of Rank Order Lists.
Mid February 2012: Applicants informed as to whether or not they were matched.
Mid February 2012: APPIC Match Day.

Immediately after learning the names of applicants with whom we have been matched, a Co-Director of Training will make contact through email and/or telephone. S/he will also be mailed two signed copies of a letter confirming the match. Each applicant is to return one signed copy of the letter confirming their agreement with the internship placement.

PSYCHOLOGY TRAINING COMMITTEE

Best, Nicole

Psy.D., Clinical, 1997, Wright State University School of Professional Psychology
Staff Psychologist, Mental Health Service
At Dayton VA Medical Center since 1999
Licensed Psychologist, State of Ohio
Professional Organizations: Ohio Psychological Association.
Clinical Interests: psychology and spirituality, geropsychology, end-of-life issues, grief work, neuro-psychology, health psychology
Theoretical Orientation: Eclectic

Bunn, Justin

Psy.D., Clinical, 2009, University of Indianapolis
Staff Psychologist, Building Bridges PRRC
At Dayton VA Medical Center since 2009
Licensed Psychologist, State of Ohio
Professional Organizations: Association of Veterans Affairs Psychology Leaders, Dayton Area Psychological Association, APA Division 36 (Religion and Psychology)
Research Interests: Religion/Spirituality and Psychotherapy
Clinical Interests: Evidence-based practice with SMI populations, recovery-focused interventions, connecting Veterans back to their communities
Theoretical Orientation: Cognitive-Behavioral, Interpersonal, Integrative

Byrd, Anthony

Psy.D., Clinical, 1989, Wright State University School of Professional Psychology
Clinical Neuropsychologist, Mental Health Service
At Dayton VA Medical Center since 1992
Licensed Psychologist, State of Ohio & Arizona
Professional Organizations: American Psychological Association (APA), Division 40, National Academy of Neuropsychology
Clinical Interests: neuropsychology, dementia, psychopharmacology.
Theoretical Orientation: Eclectic

Chaffins, Belinda

Psy.D., Clinical, 2003, Wright State University School of Professional Psychology-Dayton, Ohio
Clinical Psychologist in Mental Health
At Dayton VA Medical Center since 2010
Clinical Interests: Sexual Health, Couples, Health and Wellness, Alzheimer's
Theoretical Orientation: Cognitive-Behavioral and Humanistic

Daugherty, Paula G.

Psy.D., Clinical, 1989, Wright State University School of Professional Psychology

University of Tennessee College of Medicine Fellowship in Neuropsychology 1990
Clinical Neuropsychologist, Mental Health Service
At Dayton VA Medical Center since 2009
Licensed Psychologist, State of Ohio
Professional Organizations: American Psychological Association, Women in Psychology (WSU)
Clinical Interest: Neuropsychology, Traumatic Brain Injury, Vascular Disorders, Geropsychology, Research and Psychopharmacology
Theoretical Orientation: Eclectic

De Marchis, Massimo

Psy.D. Clinical Psychology, 1987, Wright State University School of Professional Psychology
Local Evidence Based Practice Coordinator
At Dayton VA since November 2009
Licensed Psychologist, State of Ohio (1988)
Licensed Independent Chemical Dependency Counselor (LICDC)
APA Certificate of Proficiency in the treatment of Substance Use Disorders
Fellow, American Board of Sleep Medicine
Clinical Interests: General mental health, Forensic psychology, addictions, sleep disorders
Theoretical orientation: Cognitive-Behavioral and ACT

DeShetler, Linda A.

Ph.D. Clinical, 2005, Fielding Graduate University
Staff Psychologist, Home Based Primary Care
At Dayton VA Medical Center since 2007
Licensed Psychologist, State of Ohio
Professional Organizations: American Psychological Association, (APA), Ohio Psychological Association (OPA), Dayton Area Psychological Association (DAPA)
Clinical Interests: health psychology, geropsychology, disability, terminal illness/end of life, grief/loss, faith, and resilience
Theoretical Orientation: cognitive behavioral, biopsychosocial, Adlerian

Diehl, Jane A.

Ph.D., Clinical, 1984, University of Toledo
Staff Psychologist, Substance Abuse Treatment Program
At Dayton VA Medical Center since July 2009
Licensed Psychologist, State of Ohio
Professional Organizations: Dayton Area Psychological Association, Ohio Psychological Association, American Psychological Association, APA divisions 18, 39, and 42, founding member Caring Connections (association of Dayton women private practice psychologists), International Society for the Psychological Treatment of the Schizophrenias and Other Psychoses

Clinical and Research Interests: Psychotherapy of schizophrenia and related disorders; other psychoses; dissociative disorders; borderline and other personality disorders; trauma, PTSD; adult children of physical, sexual, and emotional abuse and addictions
Theoretical Orientations: Psychodynamic, Interpersonal, Cognitive, Eclectic

Downey, Deborah L.

Psy.D., Clinical, 2002, Wright State University
Staff Psychologist, Post Traumatic Stress Disorder Program, Residential
At Dayton VA Medical Center since 2009
Licensed Psychologist, State of Ohio
Professional Organizations: APA, OPA, ABCT
Clinical Interests: PTSD; couples and families; values and identity formation
Theoretical Orientation: Eclectic with a foundation in CBT

Drake, David

Ph.D., Clinical, 1992, University of North Texas
Staff Psychologist, Mental Health Clinic
At Dayton VA Medical Center since 2010
Licensed Psychologist, State of Ohio and Kentucky
Professional Organizations: APA
Clinical Interests: Treatment of depression and anxiety disorders
Theoretical orientation: Psychodynamic

Drown, Eric

Psy.D., Clinical, Wright State University
Staff Psychologist; PTSD Outreach Services
At Dayton VA Medical Center since 2006
Licensed Psychologist, State of Ohio
Professional Organizations: APA, OPA
Clinical Interests: PTSD, geropsych, integrated mental health services in Primary Care, grief and bereavement
Theoretical orientation: Cognitive-behavioral, Existential, Integrative

Garmon, Yolanda T.

Psy.D., Clinical, 2003, Wright State University
Staff Psychologist, Psychosocial Rehabilitation and Recovery Center
At Dayton VA Medical Center since 2009
Licensed Psychologist, State of Ohio
Clinical Interests: serious mental illness; women's issues; domestic violence issues; substance abuse; family/couple therapy; group therapy; geriatric issues
Theoretical Orientation: cognitive-behavioral

Hamilton, Stephen

Ph.D. Clinical, 1992, California School of Professional Psychology-San Diego
Co-Director of Training- Psychology Internship & Fellowship Programs

At Dayton VA Medical Center since 2009
Retired, Lt Col, US Air Force, Nov 2009
Licensed Psychologist, State of Oklahoma
Research Interests: Positive psychology
Clinical Interests: Health and Wellness, Pain Management, Organizational behavior
Theoretical Orientation: Cognitive-Behavioral

Herr, Peter

Ph.D., Clinical, 2001, University of Cincinnati
Staff Psychologist, Substance Abuse Treatment Program
At Dayton VA Medical Center since 2007
Licensed Psychologist, State of Ohio
Research Interests: Substance dependence, chronic mental illness, group processes, attribution process
Theoretical Orientation: Cognitive-Behavioral, Psychodynamic

Jackson, Monica

Ph.D., Clinical, 1993, University of Cincinnati
Staff Psychologist, Dual Diagnosis Residential Program
At Dayton VA Medical Center since 2009
Professional Organizations: Ohio Psychological Association
Licensed Psychologist, State of Ohio
Clinical Interests: Chronic mental illness, substance dependence, women's issues, cultural issues, trauma
Theoretical Orientation: Cognitive-Behavioral, Psychodynamic

Noce, Maria S.

Psy.D., Clinical, 2008, Wright State University
Staff Psychologist, Post Traumatic Stress Disorder
At Dayton VA Medical Center since 2007
Licensed Psychologist, State of Ohio
Research Interests: anxiety disorders, information processing in mood and anxiety disorders
Clinical Interests: treatments for PTSD, trauma and co-occurring disorders, group psychotherapy, common factors in effective treatments
Theoretical Orientation: Cognitive-Behavioral, Integrative

Perry, Patricia A.

Psy. D. Clinical, 1996, Wright State University, Dayton, Ohio.
Staff Psychologist, Community Living Center
At Dayton VA Medical Center since 2008
Licensed Psychologist, State of Ohio (Indiana – inactive)
Professional Organizations: APA
Clinical Interests: Psychodiagnosis, psychopharmacology, resident adjustment to long term care and family caregiver stress, sexual abuse survivor treatment,

termination issues in therapy, the development of the therapist over time, managing compassion fatigue, and interdisciplinary collaboration
Research Interests: Evaluating the effective use of supervision, determining competence / proficiency in interviewing, and meeting the needs of an aging population in long-term care settings
Theoretical Orientation: Interpersonal or dynamic case conceptualization with eclectic and integrative interventions

Rodgers, Rahema

Psy.D. Clinical Psychology, 2006, Wright State University School of Professional Psychology
Clinical Psychologist with Family Services Program
At Dayton VA Medical Center since 2010
Licensed Psychologist State of Ohio
Professional Organizations: Dayton Area Psychological Association, Association of Veteran Affairs Psychology Leaders
Research Interests: Multicultural & Family Issues
Clinical Interests: Marriage and Family, Assessment
Theoretical Orientation: Cognitive-Behavioral

Rodzinka, Kristin J.P.

Ph.D. Clinical, 2005, University of Arkansas
Co-Director of Training, Acting PTSD Programs Coordinator, Military Sexual Trauma Coordinator
At Dayton VA Medical Center since 2007
Licensed Psychologist, State of Ohio (Indiana – inactive)
Professional Organizations: APA, DAPA, AVAPL, VAPTC
Research Interests: Sexual Trauma; PTSD
Clinical Interests: treatment for anxiety, depression, personality disorders, and serious mental illness; group psychotherapy; family therapy; supervision
Theoretical Orientation: Mindfulness Based Cognitive-Behavioral

Schmidt, Roger

Ph.D. Counseling Psychology, 2009, University of Louisville
Staff Psychologist/PTSD Program
At Dayton VA Medical Center since 2008
Licensed Psychologist, State of Ohio
Licensed Psychological Associate, State of Kentucky
Research Interests: Malingering
Clinical Interests: Trauma recovery, Anger Management
Theoretical Orientation: Cognitive-Behavioral; Narrative/Constructivist

Shuman, Joshua W.

Psy.D. Clinical, 2006, Argosy University-Atlanta
Staff Psychologist, Primary Care
At Dayton VA Medical Center since 2009

Licensed Psychologist, State of Ohio
Professional Organizations: American Psychological Association; Ohio Psychological Association; Dayton Area Psychological Association
Research Interests: The effects of personality factors on Axis I disorders
Clinical Interests: Motivational Interviewing; Personality Assessment; Time-Limited Psychodynamic Therapy
Theoretical Orientation: Dynamically-oriented Interpersonal Theory

Smith, Audrey L.

Psy.D., Clinical, 1999, Wright State University
Staff Psychologist, Post Traumatic Stress Disorder Program, Outpatient Services At Dayton VA Medical Center since 2008
Licensed Psychologist, State of Ohio
Professional Organizations: APA, ABCT, DAPA, AVAPL
Research Interests: PTSD; Intergenerational trauma; Cultural and traditional healing practices.
Clinical Interests: Treatment for trauma-spectrum disorders, anxiety, depression, and schizophrenia-spectrum disorders; Service accessibility for treatment
Theoretical Orientation: Cognitive, Behavioral, Existential, Integrative

Verdaguer, Ramon

Ph.D. Clinical, 1990, Loyola University of Chicago
ABPP 2004, Clinical Health Psychology
Acting Lead Psychologist/Health Behavior Coordinator
At Dayton VA Medical Center since 1996
Licensed Psychologist, State of Ohio and Illinois (inactive)
Professional Organizations: Div. 38, APA.
Research Interests: Positive psychology
Clinical Interests: Wellness and health promotion, pre-surgical psychological evaluations
Theoretical Orientation: Cognitive-Behavioral

INTERVIEW DATES AND ROTATION PREFERENCES[1]

The following worksheet is to help you organize the information we will need included in your application cover letter. Please rank all four interview dates and a minimum of three rotations. Our interns participate in three rotations during their internship year.

Interview Dates

Please rank order your preferences for interview dates. We will contact you to arrange an interview.

	Morning	Afternoon
Wednesday, January 4, 2012	_____	
Friday, January 6, 2012	_____	
Tuesday, January 10, 2012		_____
Thursday, January 12, 2012		_____

Rotation Preferences

Please rank order your three rotation preferences. Remember that, regardless of rotation, each intern spends one day per week in the Mental Health Clinic setting. Please note if you want a six month rotation for your first choice (if available).

Health Psychology		_____
Mental Health Clinic		_____
Neuropsychology		_____
PTSD Outpatient/Residential Program		_____
Substance Abuse Treatment Program	_____	
Geropsychology	_____	
Psychosocial Rehabilitation (tentative)	_____	
Family Services Supplementary Experience	Yes	No

Sample paragraphs*:

My preference for interview dates are as follows: 1) Wednesday, 1/5, 2) Tuesday, 1/11, 3) Friday, 1/7, 4) Thursday, 1/13. To best meet my training goals my rotation preferences are 1) Neuropsychology (6 month), 2) Health Psychology, 3) Geropsychology.

My preference for interview dates are as follows: 1) Thursday, 1/13, 2) Tuesday, 1/11, 3) Friday, 1/7, 4) Wednesday, 1/5. To best meet my training goals my rotation preferences are 1) Special Programs, 2) PTSD, 3) Mental Health Clinic. I am also interested in Family Services.

---

*This information MUST be included in your cover letter.